



Official Publication of the  
**MEDICAL AND CHIRURGICAL FACULTY  
OF THE STATE OF MARYLAND**

Baltimore Ear, Nose and Throat Hospital  
Part II



# Maryland

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# Maryland STATE MEDICAL JOURNAL

*Medical and Chirurgical Faculty of the State of Maryland*

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## EDITORIAL

### VOLUNTARY HEALTH INSURANCE

LESLIE E. DAUGHERTY, M.D.

Those of us who are charged with the responsibility of making voluntary health insurance acceptable and successful must recognize the importance of publicizing to the society as a whole the socio-economic chaos that would result if they were to fail. The voluntary nonprofit and profit plans have a vital responsibility to the public and to the profession because if they fail, compulsory sickness insurance in some form operated by the state will be inevitable. In almost every country that has become socialistic, regimentation of medicine has been the first stepping stone.

Our society never has been and never will be static. Changing times will see the development of changing customs. In our socio-economic system new problems will emerge which must be solved, and one of these will be a continuing demand by the public for better and more medical care. Blue Shield and voluntary insurance plans must be sufficiently flexible to come up with the answer to the social needs resulting from the constant changes in our social system.

We must develop plans that will be good enough to provide a positive answer to anything the social planners may develop. The answers provided by private enterprise will invariably be much better than those of government because they will be based on conservative liberalism and will have in them the opportunity to develop self-reliance.

No plan has ever been developed, or ever will be developed, that will satisfy all of the public all of the time. By the same token, no voluntary insurance plan has ever been developed, or ever will be developed, that will satisfy all of the doctors all of the time.

We should never lose sight of the fact that in any place in the world where medical care has been taken over by the state, money was the determining factor and the common denominator which governed the service (both medical and hospital) received by the public. This was demonstrated in England recently, where all sorts of restrictions have been thrown around the doctor who is attempting to practice medicine. These restrictions have been dictated by the fact that the plan was costing too much money.

Under our voluntary insurance plans, whether they be nonprofit or profit, we have the incentive system. In our free enterprise system we provide an opportunity for people in general to care for themselves and for their families and to do it by their own efforts.

The question now is will this protection be maintained by the voluntary system, or will it be a compulsory system supervised by the state? The answer must come from within the medical profession.

## YOUR MEDICAL FACULTY AT WORK

JOHN SARGEANT, *Executive Secretary*

The Executive Committee and Council of the Medical and Chirurgical Faculty of the State of Maryland met on the following dates and took the following action:

### COUNCIL, AUGUST 6, 1959

1. Approved appointment of a special committee on Blue Cross/Blue Shield Legislative Study as named by the president.

2. Approved the duties of the committee as follows: "to investigate and develop all information it can in respect to benefits under both Blue Cross and Blue Shield, the manner in which these services can be improved to the benefit of the public in an economical manner; and to provide supporting data in this regard."

3. Stated that, "all statements of Faculty policy be released over the names of both the president of the Faculty and the chairman of the Council of the Faculty, except in times of emergency when either one may act in this capacity."

### EXECUTIVE COMMITTEE, SEPTEMBER 1, 1959

1. Referred to the Constitution and Bylaws Committee a suggestion that, "no legal fees would be paid unless the member has a minimum of \$50,000/\$150,000 malpractice insurance or pays an assessment of \$150.00 per year in lieu of having such malpractice insurance; such amendment to take effect January 1, 1961 and applying to all cases INSTITUTED after January 1, 1961."

2. Referred to the Planning Committee the Building Committee's recommendation that there be statewide specialty sections of the Faculty, with the understanding that the Executive Committee looks toward this favorably.

3. Referred to the Public Instruction Committee, the Planning Committee's recommendation that "serious consideration be given to some type of public education program so that the public will be more aware of the differences between medical and non-medical professions," for implementation.

### COUNCIL, SEPTEMBER 17, 1959

1. Renamed Mr. G. C. Anderson as legal counsel for the coming year.

2. Stated the Council "has no objection" to the auxiliary's soliciting pharmaceutical houses for gifts and door prizes for its annual meeting.

3. Referred to the Committee on Public Instruction for implementation, the Planning Committee's recommendation that:

"The Council consider preparation of a suitable plaque for signifying membership in the Medical and Chirurgical Faculty as the Maryland State Medical Association, as an aid to informing the public and promoting better public relations. Such a plaque might bear the Maryland State Seal and the Faculty Seal, and be carefully designed so as to help ensure reasonable pride in its possession and prominent display in members' waiting rooms. Such a plaque, also, should be revoked should the privilege of membership in the Faculty be lost."

4. Referred to the Planning Committee a question of formation of a Health Insurance Council.

5. Moved that no action be taken on a letter from the Maryland Chapter, American College of Surgeons, dealing with prorating of surgeons' fees for treatment rendered in rural areas.

6. Authorized the Maryland Truckers' Association underwriting the cost of pamphlets on safety issued by the AMA for distribution to all active physicians in Maryland.

7. Was advised that the Board of Medical Examiners is submitting a change in the Medical Practice Act to increase the fee for applicants for licensure from \$35.00 to \$50.00.

### HOUSE OF DELEGATES

The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, at its Semi-annual meeting, September 18, 1959, in Ocean City, took the following action:

1. Received for the Faculty a portrait of the late Dr. William T. Hammond, a past-president of the Faculty, from his next of kin.

2. Granted emeritus membership to Dr. Harold H. Mitchell, Gaithersburg, at the request of the Montgomery County Medical Society.

3. Approved various bylaw amendments.

4. Adopted a pension plan for employees of the Faculty, to take effect April 1, 1959; and adopted a



group life insurance plan for employees to take effect October 1, 1959.

5. Adopted a suggested amendment to the Medical Practice Act as submitted by the Board of Medical Examiners, which would require reregistration of physicians licensed to practice medicine in Maryland on a biennial basis.

6. Authorized the creation of the post of assistant executive secretary.

7. Approved a resolution from the Planning Committee requiring the Faculty "work for legislation which would require Medical and Chirurgical Faculty approval of all nonprofit health plans or any changes thereto before they can become effective."

8. Approved a suggested committee reorganization, to be implemented "immediately following the 1961 annual meeting."

9. Heard a report of the Building Committee and requested it to obtain costs, after the architect prepares plans and specifications, for its proposed addition and renovation of the Faculty properties. The committee is to come before another meeting of the House of Delegates with information as to ways and means of paying for completion of its recommendations.

10. Adopted a recommendation of the Medical Economics Committee which would reaffirm the Faculty's stand on freedom of choice of physician.

11. Adopted a pupil medical record form for use in providing health data on school children throughout the state.

12. Heard a communication from Blue Cross stat-

ing that no action has been taken by the Blue Cross Board of Directors during the past six months with respect to the transfer of radiology and pathology benefits from Blue Cross to Blue Shield; and that, "it is the considered opinion of the board that any such action would not be in the best interests of the subscribers."

13. Adopted a recommendation that the House endorse a \$50.00 deductible Blue Cross contract on an optional basis.

14. Adopted a resolution commending and expressing appreciation to various members of the Attorney General's office and the State's Attorney of Baltimore City.

15. Adopted a resolution providing for the Faculty to enter actively into the field of recruitment of students for the medical, nursing and allied professions.

16. Adopted a resolution directing "its representatives to Blue Cross and Blue Shield to effect a transfer of all pathology and radiology benefits now included under Blue Cross to Blue Shield.

17. Adopted a resolution disapproving the operation of laboratories not under the supervision of physicians; encouraging members of the Faculty not to utilize such laboratories; and instructing representatives of the Faculty to Blue Cross and Blue Shield that payment for pathology services should be made only to a licensed physician.

Copies of all resolutions and actions of the House are available to members of the Faculty by requesting same from the Faculty Office.

#### UNIVERSITY OF MARYLAND HOLDS THIRD PINCOFFS LECTURE

The Third Pincoffs Lecture in Medicine will be given by Dr. Irvine H. Page of the Cleveland Clinic. The lecture will be given Monday, December 14, 1959 at 8:15 p.m. in Chemical Hall at the University of Maryland School of Medicine.

#### Mechanisms and Treatment of Arterial Hypertension

The past thirty years have seen wide changes in our views on the mechanism and treatment of hypertension. The renal mechanisms will be especially considered because of recent knowledge in understanding of the basic chemical mechanisms and methods of diagnosis and treatment. New drugs such as Guanethidine and Darenthine will be discussed. An attempt will be made to give perspective rather than detail.

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# Baltimore Eye, Ear and Throat Hospital

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## Part II\*

### THE MANAGEMENT OF SOME COMMON PEDIATRIC EYE PROBLEMS

ARNALL PATZ, M.D.

#### VISION TESTING IN INFANTS AND YOUNG CHILDREN

A complete pediatric examination should always include an estimate of the patient's vision. The selection of the best test to use should be determined by the patient's age, I.Q. and general cooperation. In testing visual acuity, it is important to test each eye separately whenever possible. With the uncooperative youngster, making a game of wearing a pirate's patch or putting a patch on the parent's eye is sometimes helpful in occluding the eye not being tested. An amblyopic eye may be suspected if the child objects to the patching of one eye (the better eye) but does not complain when the weaker eye is patched.

Children of school age usually can be tested on the adult Snellen letter charts. Here the results of the test are expressed as a fraction where the numerator indicates the distance from the patient to the chart and the denominator, the line on the chart which he reads from this distance.

Children from ages four through six can usually be tested with the illiterate E chart. Here the patient points the direction of an E on a Snellen chart or on an individual E target. A convenient form of the E game is now available as a set of single letters on washable plastic plates. Occasionally a child of three who is intelligent and cooperative can master the E game quickly.

Testing of vision in children between the ages of approximately two and three years presents the greatest challenge to the pediatrician. Holding up

small toys across the room for identification is frequently effective. Worth's method of throwing different sized marbles across the room and basing acuity on the child's ability to retrieve the objects is sometimes effective. Where the patient is recalcitrant, lollipops of different sizes can be substituted and thrown across the room to be retrieved. This has frequently worked well with a child who refused to cooperate on any other phase of the examination.

With infants, several techniques can be utilized. Until two or three months of age the eye movements are frequently uncoordinated. However, the ability to follow a bright source of light is present. The presence of the pupillary response to light and the orbicularis blink reflex on exposure to bright light give a crude clue to the probability of some degree of vision being present. After three or four months of age, the child will normally follow a large, bright object moved across the field of vision. After eight or nine months of age, the infant will frequently reach for an object held nearby and will follow smaller objects. The principle of optokinetic nystagmus can be utilized in infants where more quantitative evaluation of vision is indicated.

In general, a slight reduction of visual acuity in both eyes so that the vision, although subnormal, is essentially equal is not as urgent a problem as when one eye is found markedly reduced in vision (amblyopic) and the fellow eye essentially normal. Where defective vision is noted a careful ophthalmoscopic examination, refraction and evaluation of the extra-ocular muscle balance should be done routinely. However, the child with grossly defective vision in one eye should be examined promptly, and immediate attention given to this defect. Early

\* All articles in this issue relate to diseases and problems of ophthalmology. Papers on ear, nose and throat appeared in Part I of the Baltimore Eye, Ear and Throat Hospital issue, October 1959.

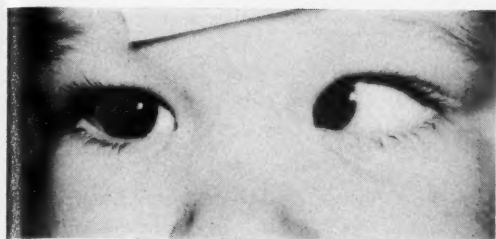


FIG. 1. A. A., age 15 months: marked convergent strabismus, left. Note relative position of flash bulb reflections in each eye.

treatment of an amblyopic eye by the correction of any existing refractive error and occluding the good eye may enable vision to be developed.

Occlusion therapy is most effective in the very young child, and the therapeutic results are generally inversely proportional to the age of the patient up until about eight or nine years of age. After this age, occlusion therapy is usually ineffectual but should always be tried.

#### STRABISMUS

A brief outline of strabismus is cited here; however, pediatric aspects of its identification and management are discussed in more detail. Photographs illustrating various types of strabismus are presented (figures 1-9). Strabismus may be simply classified into convergent, divergent or vertical deviations. One eye will deviate consistently, or the deviation may alternate between the two eyes. The deviation may be constantly present or noted only intermittently. For a detailed but concise discussion of strabismus, the reader is referred to the article by Costenbader and Albert (1).

In testing for strabismus in the pediatrician's office, the light test and cover test are probably the most feasible and simple to perform. In the light

test a small hand light or flashlight is aimed at the eyes from about two feet distance. If the light reflex is in the center of each pupil, the eyes are straight (see figures 1-9). The cover test is performed by gaining the child's attention on an object, such as a small toy, lollipop or light, and alternately covering one eye then the other. If the eye under cover doesn't move as the cover is removed then the eyes are straight. The cover test should be done fixing both a near and a distant object.

#### *Convergent Strabismus*

Convergent strabismus (esotropia), secondary to hyperopia and correctable by the simple wearing of plus lenses, is classified as accommodative strabismus. Esotropia may also be non-accommodative where glasses do not alter the deviation (figure 1).

A short case report is cited to illustrate accommodative convergent strabismus. B. G., a five-year old boy (figures 2a and b) was seen by his pediatrician because his mother thought the left eye occasionally crossed. The pediatrician examined the child's eyes carefully and recorded the visual acuity as 20/30 in each eye with the E game. On the cover test, using a light for a near target, he found the eyes perfectly straight. There was slight epicanthus, and the examiner attributed the mother's observation to the epicanthus simulating esotropia. He referred the patient for further evaluation, however.

On my examination the identical findings as observed by the pediatrician were noted. During examination the mother added that the eyes crossed at the dinner table, especially when he ate corn on the cob. On showing the patient several small near targets consisting of progressively smaller E's on the E game and small toys, he simply complained of blurred vision, but the eyes remained straight. A lollipop with a small label on the wrapper was then

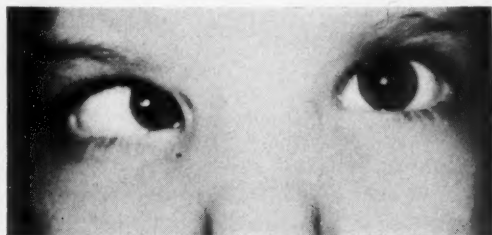


FIG. 2 a. B. G., age five: marked crossing of right eye on near fixation of small target.



FIG. 2 b. Same patient wearing plus lenses to correct far-sighted defect. On near fixation of small target eyes are straight with glasses worn.



FIG. 3. A. M., age one: mild convergent strabismus, left eye. Note that flash bulb reflection is centered in right pupil while reflection in left eye is displaced to edge of pupil.



FIG. 4 a. S. R., age five years: on distance fixation there is a marked divergence of the left eye.

presented as a near target. The child's right eye promptly crossed to 35 to 40 prism diopters deviation as he fixed on the small label on the lollipop (figure 2 a). Cycloplegic refraction with drops revealed six diopters of hyperopia for each eye. Glasses were prescribed to correct the hyperopia (far-sightedness), and the eyes remained straight at all times with glasses worn (figure 2 b).

In analyzing this case it is apparent that this five-year-old patient, who had a large amount of accommodative power, didn't have too much of a problem accommodating six diopters to see distant objects clearly. However, the extra three to four

image due to overconvergence. As a result he seldom focused a near object unless an especially interesting stimulus was presented. This extra accommodative effort was associated with an overconvergence or crossing of the eyes.

#### *Divergent Strabismus*

In these cases a frequent history is when a child is inattentive or day dreaming, one eye will drift temporarily. Frequently the parent will note that one eye closes in bright light. In many instances on near fixation the eyes are straight (figures 4 a and b).



FIG. 4 b. Same patient on near fixation: the eyes for near are straight. The patient demonstrates an intermittent divergent strabismus present only for distance fixation.

When confronted with this history the pediatrician should always perform the cover test, with the patient fixing a distant object in addition to the near cover test, which may be essentially normal. Sometimes it is helpful to allow the child to fix on a distant object looking out of the window and repeat the cover test several times. This technique may elicit a divergent deviation that is missed on a routine near cover test.

#### *Vertical Strabismus (Hypertropia)*

A few photographs illustrating some of the types of vertical deviation that may be encountered are



FIG. 5 a. P. M., age four: overshoot upward of right eye when left eye fixes.

diopters required to see near objects clearly was rarely utilized without strong motivation for clear vision for near. The added effort apparently caused some discomfort or possible awareness of a double



FIG. 5 b. Same patient showing overshoot upward of left eye when right eye fixes. This patient demonstrates an overaction of the inferior oblique muscle, which is one of the elevator muscles in each eye.

shown in figures 5 and 6. These cases show the importance of an evaluation of the ocular muscles in



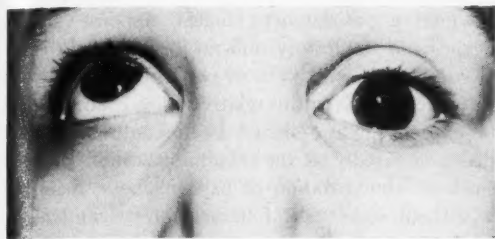


FIG. 6. Total paralysis of elevation left eye (left superior rectus and left inferior oblique paralysis). Eyes are grossly straight in all other positions except on upward gaze where left eye fails to rotate up.

all the cardinal positions of gaze. The patient should be required to fixate an object in the upper and lower fields to both right and left sides when strabismus is suspected.

#### TIME OF REFERRAL OF STRABISMUS PATIENTS

The old adage of waiting to see if the child outgrows the defect before obtaining a thorough eye examination is a bad one. In general referral to an ophthalmologist should be made the *first* time the deviation is detected or strongly suspected by the pediatrician. The goal in the treatment of strabismus is to obtain the best possible vision in each eye, to align the eyes as early in life as feasible and to develop binocular vision with good fusion and depth perception.

Where strabismus is noted in a young infant, I have found the ideal time for ophthalmological examination to be five months of age. The newborn infant up to two or three months is uncoordinated in its eye movements. By five months any persistent deviation of the eyes will remain in a significant number of children. The five month old infant is an ideal subject for examination. When hungry he can easily be pacified with a bottle, and an accurate cycloplegic refraction and detailed examination of the eyegrounds can be made. The parents should always be instructed, however, to make the appointment at a feeding time and to bring with them a full bottle for use during the examination. With knowledge of the refractive status and the eyegrounds available, subsequent evaluation of the strabismus can then be done with confidence.

After nine to twelve months of age it may be difficult to pacify the infant for adequate ophthalmoscopic examination and refraction, and a general anesthetic may be occasionally required to obtain the same information. The pediatrician should not overlook the possibility that a constantly deviating

eye may harbor a retinoblastoma or some inflammatory lesion (figure 7) when considering the optimal time for referral.

#### EPICANTHUS SIMULATING CONVERGENT STRABISMUS

The pediatrician is frequently confronted with a child whose parents or neighbors are convinced that the eyes are crossed. A young child with a broad flat nasal bridge, prominent epicanthus and narrow separation between the eyes simulates esotropia (convergent strabismus) (figures 8 and 9). This



FIG. 7. E. J., age five: right eye is divergent on both near and distance fixation and exotropia is constant. Right eye is amblyopic and shows retinal scars of aborted retrolental fibroplasia.



FIG. 8. B. J., age 2 years: wide bridge of nose and prominent epicanthus simulate convergent strabismus. This is especially noted in left eye as fixation object is moved slightly to right. Note reflection of flash bulb centered perfectly in each pupil, showing that eyes are actually straight.



FIG. 9. M. G., age six months: wide bridge of nose and prominent epicanthus simulate strabismus. Flash bulb reflection is centered in each pupil, showing that eyes are straight. Compare with figures 2 a and 3.



pseudostrabismus is due to less white sclera being visible nasally than one expects to see, and the interpretation is that the eyes are crossed. This is especially noticeable when the child looks to one side (figure 8).

The pediatrician can differentiate true strabismus from pseudostrabismus by shining a light in front of the patient. If the light reflexes are centered in each pupil, the eyes are straight. A more accurate test is the cover test. Here the child fixes on a small toy or flashing light, and the examiner alternately covers one eye then the other. If the eyes are straight, no shift of the covered eye is noted when the occluder is transferred to the other eye.

#### RETROLENTAL FIBROPLASIA

Now that rigid curtailment of oxygen administration to premature infants is generally routine in the nursery, retrolental fibroplasia has been dramatically reduced compared to its previous incidence of approximately 20 per cent of all infants with birth weight less than three pounds (2, 3). An occasional case, however, still occurs, and the pediatrician should exercise extreme caution where oxygen therapy is administered. The increased susceptibility of twins to oxygen and to retrolental fibroplasia should sound an especially strong note of caution in the administration of oxygen to infants of multiple births.

The following general recommendations on oxygen administration to prematures that have been cited elsewhere (4) are cited below:

1. Every nursery should be equipped with an oxygen analyzer.
2. The incubator oxygen concentration should be measured and recorded at least three to four times daily.
3. A special oxygen chart or some system of recording oxygen concentrations on the standard hospital chart should be provided.
4. Except for emergency use, oxygen administration to the premature infant should require a doctor's order. This order should state the percentage of concentration and not the flow rate of oxygen.
5. The initial order for oxygen should state a definite time in hours of administration, and attempts to terminate or reduce the concentration should be made on an hourly basis.
6. The concentration of oxygen ordered should be, in general, the minimal concentration required

to give a satisfactory clinical response. When cyanosis or respiratory difficulty exists, an attempt to control this with 35 to 40 per cent oxygen should be made first. Even this relatively low concentration of oxygen therapy should be discontinued or reduced as rapidly as the infant's condition permits, since no concentration of oxygen above room air is without some risk of inducing retrolental fibroplasia.

Since no treatment is accepted as beneficial in retrolental fibroplasia, the early detection of the retinopathy is primarily of academic interest only. However, the eyegrounds of every premature infant should be ultimately examined with the pupils dilated. The ideal time of this examination should be at four or five months of age. If no evidence of retrolental fibroplasia has appeared by the fourth month, the examiner can assure the parents with confidence that it will not develop subsequently. At this age, with a bottle or sugar nipple, the hungry infant will almost invariably be pacified so the eyelids are relaxed without squeezing, and a careful eyeground examination can be made.

#### CONGENITAL GLAUCOMA

Congenital glaucoma is a relatively rare occurrence in the average pediatrician's practice. Brief reference is made to this condition here, as the only likelihood of salvaging vision rests in the early detection and treatment of the condition before gross deformity of the globe follows long sustained raised intraocular pressure.

The best clue for the presence of congenital glaucoma is an enlarged cornea. Up to 11 mm. is acceptable as within normal limits of corneal diameter, and any measurement exceeding this should prompt careful evaluation of the ocular tension. In more advanced glaucoma the corneal diameter, in addition to being enlarged, may show fine striae which represent folds in Descemet's membranes. Prompt ophthalmological referral for evaluation of tension and aqueous outflow is indicated (5).

#### CONGENITAL OBSTRUCTION OF NASOLACRIMAL DUCT

This condition is probably seen much more frequently by the pediatrician than by the ophthalmologist. The typical history is that of a recurrent mucoid or mucopurulent discharge from the inner corner of one eye present from birth. Rarely

the condition may be bilateral. The parents report crust formation on the lid margin and frequently in the inner canthus and excess tearing on the affected side.

There are two diametrically opposed schools in management of congenital lacrimal duct obstructions. Cassady (6) and Broggie (7) advocate early probing within the first few weeks of life. They cite the simplicity of probing at this early age and that no abnormal obstruction is noted at the nasal end of the duct. When probing is deferred, they report, the obstruction at the lower end of the lacrimal duct is more resistant.

The opposing school handles the problem more conservatively. This group recognizes that in about 90 per cent of infants the obstructed tear ducts open spontaneously or by simple massage by six months of age. Probing, even though a simple operation, is actually a needless procedure in those cases.

I adhere to the conservative school and do not advocate probing until six months of age. Massage of the tear sac is recommended as soon as the condition is detected. Before instructing the mother on the method of massage, a simple sketch of the tear

apparatus, similar to that in figure 10, is demonstrated. She is instructed to first place the index finger over the inner corner of the eye to occlude the upper and lower punctum, then roll the finger toward the nose over the tear sac. Massage is then firmly applied over the sac so as to produce positive pressure downward toward the lower end of the lacrimal duct. If the mother's nails are long, the one used for massage must be trimmed short to avoid risk of inadvertently abrading the cornea. Massage is done three to four times daily. If the tear duct has not opened by six months of age, probing under light inhalation anesthesia is advised.

#### SUMMARY

Several ophthalmological problems encountered by the pediatrician are presented briefly. Emphasis is placed upon proper diagnosis by techniques that are routinely available in the pediatrician's office. Recommendations for the pediatric management of these conditions are discussed.

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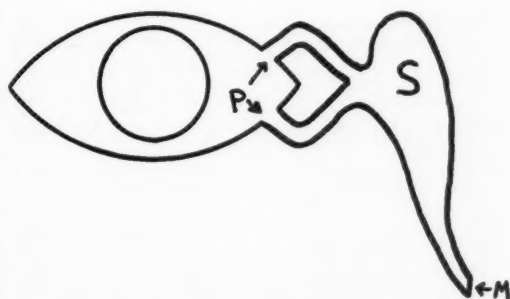


FIG. 10. Schematic diagram of nasolacrimal system. P—upper and lower punctum, S—lacrimal sac, M—mucous membrane covering terminal end of nasolacrimal duct in inferior meatus of nose.

#### OPPORTUNITY FOR PHYSICIANS

The E. I. duPont de Nemours Company is interested in talking with any young doctors who are considering a career in industrial medicine. Several openings exist for such men in their Construction Division.

Prospective applicants may write to them at Post Office Box 3457, Baltimore 26, Maryland, or call ELgin 5-0600.



FIG. 1. A child with rhabdomyosarcoma of the right orbit



FIG. 2. Exenterated orbit

## EXENTERATION OF THE ORBIT

CHARLES E. ILIFF, M.D.

### EXENTERATION OF THE ORBIT

In the past exenteration of the orbit was considered such a mutilating operation that even after a confirmed tumor diagnosis had made the operative course clear, the surgeon some times procrastinated. When such a delay occurred, inoperable local extension or metastases resulted. Today, operation can be recommended without hesitation, as the prosthesis artist, with new techniques in plastics, can so skillfully conceal the exenterated orbit that the result challenges scrutiny. Every detail can be imitated except motion of the lids and globe, and the patient can return to normal life two months after operation, fully confident that a cosmetic barrier will not hamper future activities.

### INDICATIONS

Exenteration of the orbit is required when a neoplasm so involves the lids, the globe, or some part of the orbital contents that simple excision or irradiation will not suffice. For instance, exenteration is necessary for spreading melanomas of the conjunctiva; choroidal melanomas that have broken through the sclera; malignant melanosis; orbital sarcomas, with the exception of lymphosarcomas, which are best treated by irradiation; carcinomas

of the lids which have invaded the orbit, and tumors of the lacrimal gland which have extended beyond the capsule.

Exenteration is not indicated for pseudotumors or limbal carcinomas. Also, it should not be used for metastatic lesions, unless local pain associated with rapid tumor growth can be controlled in no other way.

Formerly the surgeon was confronted with the question of whether to save the lids to produce a better cosmetic result or to remove them to insure total tumor excision. Today, cosmetic perfection in fitting and wearing the modern plastic prosthesis depends upon a clean epithelized socket with firm, well defined orbital margins; and this is best obtained by removing the lids.

### TECHNIQUE

General anesthesia with intubation is required. Only moderate blood loss is expected, but the patient's bleeding history and bleeding and clotting time should be known, and an intravenous saline drip run during the operation. This can be followed by blood or plasma if necessary.

The lids, conjunctival sac and skin around the eye are cleaned with aqueous Zephiran® (benzalkonium



FIG. 3. Left, exenterated orbit. Right, child wearing prosthesis. (Prosthesis artist, Felix Weinberg)

chloride). The graft donor site, the inner surface of the thigh, which carries less hair, is cleansed in a similar manner and shaved, if necessary. Both areas are draped with sterile towels and an operative sheet.

The head is rotated slightly to the affected side, so blood will drain laterally and not pool in the eye or operative field. The incision line, unless the tumor extension demands a wider excision, is along the orbital rim below the eyebrow. A Bard Parker no. 15 knife is used, starting the incision from the upper nasal orbital rim to the lateral canthus, down through skin, subcutaneous tissue, muscle and periosteum to the bone. Pressure is immediately applied to control bleeding until hemostats can be placed on spurters. When bleeding has been controlled by cautery or fine catgut ties, the incision is extended from the upper nasal quadrant, along the nasal and inferior orbital rim to the lateral canthus.

The incised periosteum around the orbital rim is loosened with a periosteal elevator. This stripping should be started in the upper temporal quadrant, where the bone is thicker and where there is a good plane of cleavage. The periosteum strips easily as far as the upper nasal quadrant, where the trochlea must be detached by sharp dissection.

Special care is taken in elevating the periosteum of the nasal orbital wall over the thin ethmoid plate. The medial and lateral canthal ligaments are firmly attached to the bone and are best severed with the Bard Parker knife. The periosteum can be freed as far as the apical stump and the extensions along the superior and inferior orbital fissures. Heavy, curved enucleation scissors are then directed back along the temporal orbital wall to include the whole apical stump in their bite and to sever it as close to the bone as possible. The orbital contents are removed, the orbit immediately packed with dry gauze and pressure applied to control bleeding. The application of pressure is continued by an assistant while the skin graft is being cut from the leg.

The Stryker dermatome has proven ideal in ocular surgery to cut a graft two inches wide by four inches long and .006 inches thick. A clear plastic adhesive tape, made for dermatome use, is placed on the skin of the inner surface of the thigh which is held on stretch. The dermatome, with the gauge set to compensate for the thickness of the plastic, is then applied over the plastic and the graft cut with firm pressure; otherwise the graft may be quite irregular and tattered. The dermatome is directed away from





FIG. 4. Steps in making orbital prosthesis. (Felix Weinberg)

the surgeon, since the graft with the attached plastic presents itself in a strip ahead of the knife. The donor site is dressed with antibiotic ointment and covered with vaseline gauze and a firm pressure bandage.

The gauze pack is now removed from the orbit and any slight bone ooze is controlled with bone wax. The apical stump should be heavily fulgurated or so completely cauterized that it insures destruction of all tumor tissue and requires no suture of any sort.

The graft, still on the plastic tape, is shaped into a cone with both the large and the small ends open. The overlapping sides of the cone are now cut and stitched together by an Ethicon atraumatic needle carrying six zero black silk. It is important that the apex of the cone be left open to permit adequate immediate drainage from the apical stump. To promote further drainage, several stab holes are placed over the areas of the inferior and superior fissures. After the shaping of the cone has been completed, the skin is removed from the plastic. The outer edge of the cone is then carefully sutured to the skin of the orbital rim with many closely placed (three millimeters apart) six zero black silk sutures. The graft is pushed into the orbit and under tension should cover smoothly all but the apex. A thin conical layer of sterile sea sponge, shaped exactly like the graft, is placed in the socket, and in its center are packed smaller pieces of sea sponge to give firm lateral pressure, producing a tight contact with the bone. The outer dressing is of gauze fluff, held in place by an elastic bandage.



FIG. 5. Front of orbital prosthesis

#### POSTOPERATIVE MANAGEMENT

Antibiotics, administered parenterally, are used to minimize the possibility of infection. Postoperative pain in the orbit is slight, but the site of the donor graft may cause discomfort, and this should be controlled by codeine, as necessary. The patient is permitted up as desired and need be kept in the hospital only eight to ten days. The pressure head bandage is removed after 48 hours and replaced with a gauze fluff held in place by adhesive tape. The orbital pack itself is not disturbed for ten days, and then only the center portion is removed. The removal of the central sponge sections permits the peripheral conical pack to separate slowly from the graft, so that removal a day or two later is less likely to disturb the new epithelium. The orbit is not repacked. The graft is cleansed gently with aqueous Zephiran®, and a slight coating of antibiotic ointment is spread over any weeping areas to prevent formation of hard crust. Ointment should be used on both the rim and the eye pad to prevent drying. Dressing should be changed daily, but vigorous cleanup must be avoided. The patient is usually ready for a prosthesis in six weeks.

#### DISCUSSION OF POSSIBLE COMPLICATIONS AND THEIR MANAGEMENT

Immediate grafting of the orbit, as advocated by Kirby in 1931, was one of the greatest advances in orbital surgery. Previous to this, the orbit was permitted to granulate and pinch grafts were placed on these granulations. The procedure demanded a long



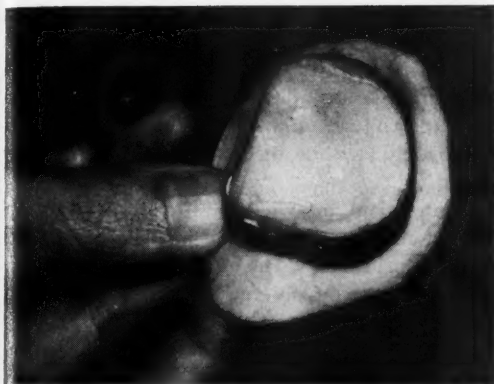


FIG. 6. Back of prosthesis



FIG. 7. Prosthesis being fitted



FIG. 8. Final fitting: glasses help to cast shadows and break any skin-prosthesis lines

hospital stay, a second operation, and produced a difficult postoperative course. The preoperatively depressed patient became involved in a painful postoperative orbital problem, which necessitated psychiatric encouragement as well as ophthalmological care.

Kirby's method, which employed a split thickness

graft applied to the freshly denuded bone, shortened the usual postoperative course of two to three months hospitalization to four to eight days, and permitted the patient to return to normal life in six to eight weeks. The immediate grafting gave better coverage and reduced the possible complication of osteomyelitis of the bone from a long standing

secondarily infected orbit. With the old method of granulation followed by pinch grafts, a low grade secondary infection was common. This was before the era of antibiotics, and osteomyelitis of the orbital wall frequently occurred, which in several instances was followed by a brain abscess or meningitis. With the present method of grafting the orbit there have been no such occurrences.

The importance of a smoothly stretched, thin (.006 inches) graft cannot be overstressed. A thick graft makes primary healing of the donor site slow and painful, and the graft itself does not take well. A slough of the superficial layers of the graft is a prime medium for infection. Folds become necrotic, as only cells in contact with bone remain viable. Freehand cutting of the graft is extremely difficult, at least in most hands. Some old masters still maintain that modern dermatomes are not necessary, but it is sufficient to say present complications are minimal compared to reported ones in the past. On one occasion skin grafting of the donor site was later necessary where an overly deep freehand cut had been made. In another a *full* thickness freehand graft was placed on bare bone, the graft sloughed and the secondarily infected orbit resulted in meningitis and death of the patient.

With the Stryker dermatome a rapidly oscillating blade cuts a graft two inches wide and any desired thickness or length. A sterile, clear plastic adhesive tape is used to get good skin stretch and contact with the blade. The tape prevents the skin from curling into a small ribbon and makes shaping and handling of the graft much easier. The cone of skin to fill the orbit can be exactly formed, the edges trimmed, fitted, and joined before the plastic is removed. Special note is called to the small end of the cone, which is left open, since no skin should be placed immediately over the fulgurated area at the apex of the orbit. A take will ultimately occur in this area from cell proliferation from the sides. If the apex is covered, drainage may be trapped and the graft lifted. Stab incisions in the wall of the skin also facilitate drainage. The cone method of fitting the skin into the orbit has proven extremely satisfactory and far surpasses the old method of stretching the skin over a gauze or wax mold.

At the time of the first orbital dressing, areas of doubtful take may be noticed. These areas should not be disturbed as many will survive or epitheliza-

tion will close in from the viable areas at the sides. Immediate postoperative infection with thin grafts has been rare. A 1/1000 Zephiran® wash has proven excellent for keeping the orbit clean. If any infection is noted, cultures and sensitivity studies should immediately be made and proper antibiotic therapy started.

Exenteration following transfrontal craniotomy with the removal of the orbital roof should be done with extreme caution. The orbit of one patient was exenterated for a rapidly growing tumor three months after the transfrontal approach had been done. The frontal lobe herniated into the orbit, and seven operations were necessary to control the prolapse. This could have been avoided if a tantalum plate had been used to cover the defect in the orbital roof.

Postoperative x-ray therapy for possible retained sinus tumor may well cause a breakdown in the newly grafted orbit. This occurred in one case producing an opening into the nasopharynx. The patient refused further operation and wore a cotton pack in the orbit and black patch.

Recurrence of the tumor at the edge of the grafted orbit stresses the importance of wide excision. Should it occur, immediate reoperation is indicated. Each case produces its own problems and generalizations can not be made, but the lesion should be attacked promptly and the recurrence removed.

Paresthesias of the skin around the orbit, resulting from the severing of the nerves, must be explained to the patient as a normal occurrence. In only one case did severe facial pain occur, causing the necessity of section of the trigeminal nerve. The origin of the pain was questionable in this case.

Enucleation to facilitate the operative procedure of exenteration is not necessary and should not be done as the tumor field is opened unnecessarily.

The use of temporalis muscle to fill the orbit, as advised by Naquin, is not applicable with the modern plug type of orbital prosthesis. It was used in an orbit in which secondary infection could not be controlled many years after an evisceration of the orbital contents had been done. The lids had been saved and the reported result was good.

#### SUMMARY

Technique for orbital exenteration which produces few complications is presented.

The education of the public has produced an awareness of the importance of early medical advice, so the tumor patient usually presents himself when complete eradication of the lesion is possible. The present orbital prostheses are cosmetically so satisfactory that any hesitancy on the part of the surgeon to undertake the operation should no longer exist. For the best cosmetic result the lids should not be

saved, so even the need for making this decision does not arise.

Early tumor surgery is vital and results gratifying; it must be stressed that the operative risks, whether from morbidity or mortality, should never exceed the risks from the tumor itself.

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## MANAGEMENT OF HEMORRHAGES IN THE ANTERIOR CHAMBER

ERNST BODENHEIMER, M.D.

One of the problems in ophthalmology which still awaits satisfactory solution is that of hemorrhages into the anterior chamber of the eyeball. Their accurate name is *hyphema*—not *hyphemia*. Small hemorrhages of this type are of no serious concern because they frequently are absorbed spontaneously. Only careful observation is needed in order to prevent complications. The prognosis of hyphema is less optimistic when blood occupies a large part of the anterior chamber. With the anterior chamber completely filled with blood, the outlook grows serious in regard to preservation of vision and even to survival of the eyeball.

The first factor which endangers vision is the hemorrhagic infiltration of the cornea. Once this infiltration has set in, the cornea loses its transparency completely in the course of a few days. Iris and pupil are veiled by a dense greyish-white interstitial disc. Only a narrow peripheral zone of the cornea remains clear. The clinical appearance resembles, in many respects, the end state of an interstitial keratitis. It is obvious that the discolored cornea looks quite disfiguring, but worse, often, is the permanent loss of all useful vision.

The other factor which may dim the outcome of

hyphema is secondary glaucoma. Filtration operations, miotics and Diamox®, are known to give little promise. Therefore the procedure usually resorted to is paracentesis of the anterior chamber by a small opening at the limbus, or a wider incision at the limbus followed by lavage of the anterior chamber. Sometimes instrumental removal of the blood clot is attempted. These surgical procedures are at times successful, but recurrence of the hemorrhage is frequently encountered, either immediately or a few days after the initial success. Discouraged by the tendency of hyphema to recur after remedial surgery, many ophthalmologists decide to "sit tight" and wait for spontaneous absorption. Experience seems to show that the results of judicious waiting are no worse than those of a more aggressive surgical attitude.

If we consider anew the dangers of extensive hyphema, we become aware that we deal primarily with two problems:

- (1) The problem of secondary, intractable glaucoma.
- (2) The problem of hemorrhagic staining of the cornea with subsequent loss of vision.

In 1944 I became interested in solving this second

problem of hemorrhagic corneal staining. My plan was to separate the corneal endothelium from the blood clot in the anterior chamber by a layer of air. By preventing contact between clot and cornea, one can expect to keep the cornea clear and preserve its normal transparency. Injection of air into the anterior chamber presents no difficulty to the ophthalmic surgeon. The uses of air injection were described in a comprehensive survey by Hughes and Cole (1) in 1946, but the relief of hyphema problems is not mentioned in this paper. This procedure was first used in an eye which appeared to be doomed. It had no light perception and was ready for enucleation because of intolerable pain.

#### CASE REPORT

On February 25, 1945 Mrs. J. S., 53 years old, was admitted to the Baltimore Eye, Ear and Throat Hospital. The diagnosis was acute glaucoma, left eye. Examination revealed the left eye to be congested. The cornea was edematous and the pupil dilated. Tension was 3 plus. The fundus was barely visible. The nerve head showed no glaucomatous excavation. Intra-ocular tension was temporarily relieved under Eserine® but rose again after 24 hours. On February 27, 1945 glaucoma iridectomy on the left eye, under local anesthesia, was performed by Dr. J. S. Friedenwald. March 1, 1945: the anterior chamber was filled with blood. March 11, 1945: hyphema had filled the anterior chamber completely and showed no sign of absorption, intraocular tension was 3 plus. The cornea was edematous. The incision wound was slightly bulging. The patient was in distress and vomiting. Dr. Friedenwald referred the patient to me after discussing the advisability of enucleation. Enucleation was planned for the following morning because of intractable pain in a blind eye. The patient, convinced that no procedure could render the situation worse than it was, consented to an injection of air into the anterior chamber.

March 12, 1945: After sedation and local anesthesia, including retrobulbar injection of novocain 2 per cent, the cornea was entered 1 mm. inside the limbus with a discission knife. The knife traveled 2.5 mm. through the cornea in a plane parallel to the iris before entering the anterior chamber. A 27 gauge blunt needle attached to a 2 cc. air filled syringe followed the path of the discission knife. About 0.1 cc. of liquid blood could be withdrawn into the syringe. At

this moment the corneal epithelium became more glistening. Immediately air was injected into the anterior chamber, while the tip of the needle was held firmly in place to avoid damage to the structures of the anterior chamber. At the end of the procedure a layer of air bubbles was visible between blood clot and cornea.

March 13, 1945: The patient was more comfortable, vomiting had subsided and the surgical incision no longer bulged. The air bubbles in the anterior chamber were still present. The blood in the anterior chamber, previously a dense, black mass, was now loosened by fluffy red spots. The intra-ocular pressure taken by finger touch was not high. Absence of pain, flattening out of the incision wound and the smooth surface of the cornea seemed to confirm this impression. The plan for enucleation was canceled.

March 15, 1945: Blood in the anterior chamber was rapidly absorbing. Tension was normal.

March 18, 1945: Mild congestion was still present; hyphema was 2 mm.; fundus detail was not visible. Fluffy clouds of hemorrhage appeared in the vitreous. Vision in the left eye was revealed by a finger count from five feet. The patient was discharged.

March 27, 1945: The left eye was pale; the anterior chamber clear. Vitreous hemorrhage was nearly absorbed. Vision was 20/40 partially, without glasses.

April 3, 1945: Vision in the left eye was 20/25 with +1.50 sph. -1.00 cyl. X 15. The nerve head was somewhat pale, but with no pathological excavation. Intra-ocular pressure with a Schiøtz tonometer was 5.5/4.5; 10/8. No miotics were used. Left visual field was normal with no Bjerrum defect. Size of the blind spot was normal.

February 11, 1947: No change was noted.

October 13, 1952: Intra-ocular pressure in the left eye, measured by a Schiøtz tonometer, was 5.5/5; 10/8. Vision and field were unchanged.

The conclusion from this experience is that the air injection had not only protected the cornea from blood staining; it had also the unexpected effect of hastening the absorption of blood from the anterior chamber. While the prevention of the corneal blood staining was the result of planning, the speedy absorption of hyphema was unexpected and needs explanation. One can assume that air which takes added space in the anterior chamber spreads the angle, opens thereby the Fontana spaces and facilitates the drainage of liquefied blood through the fil-



tration passages. The air in the anterior chamber may also hasten the liquefaction of the clot. This question can only be answered by further investigation.

This case is reported in detail because it encouraged the use of air injection in similar situations during the following years. Eight more patients with hyphema with complete hemorrhagic filling of the anterior chamber were treated by the same procedure. Hemorrhagic staining did not occur in any of these patients; nor was there recurrence of hemorrhage or secondary glaucoma. In one patient with a large hyphema six days after cataract surgery, air injection was considered not immediately indicated because intra-ocular pressure remained normal. On the tenth day postoperatively, hemorrhagic staining of the cornea was noted, which became dense and permanent. Intra-ocular pressure taken two weeks postoperatively was Schiøtz 5.5/6; 10/9. This observation is recorded here because in most textbooks (2) elevated intra-ocular pressure is considered a necessary factor for hemorrhagic corneal staining. Probably any defect of the corneal endothelium facilitates corneal staining. The defect may be caused by excessive intra-ocular pressure, by lesions from surgical manipulation or by spontaneous tissue lesions, e.g. Fuchs endothelial dystrophy.

Seven subsequent cases of hyphema treated by me are not enough to permit statistical conclusions. Air injection was used only on eyes in which the anterior chamber was completely filled with blood. Therefore the number of my cases is limited.

In 1954 Wilson, McKee, Campbell and Miller (3) reported 34 successful treatments of hyphema by air injection with no failure. These authors advocate air injection even in cases of moderate size hyphema, without waiting until secondary bleeding causes an alarming condition. They repeat the air injection if continued bleeding is observed.

Personal communications with Baltimore colleagues made me aware of repeated failures. In all these disappointing cases, air injection was used as a last resort, after other procedures had failed or after a period of hopeful waiting. In the meantime pathological changes develop which militate against success of air injection. The blood clot in the anterior chamber becomes organized. It blocks the pupil or it blocks the chamber angle by rapidly forming adhesions. This causes secondary glaucoma beyond repair. (Ophthalmic Pathology Atlas and Textbook. J. S. Friedenwald et al., 1952 (4).) The hesitancy to use air injection promptly is understandable since experience with this procedure is still limited. However, eyes have unquestionably been saved by injection of air, and eyes have been lost by reluctance to act at the proper time.

#### SUMMARY

This report attempts to show:

- 1) That air injection into the anterior chamber can prevent hemorrhagic staining of the cornea.
- 2) That air injection apparently hastens absorption of blood from the anterior chamber.
- 3) That absence of elevated intraocular pressure is no assurance against hemorrhagic corneal staining.

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## Dead Wood

You'd be surprised the ideas our ancestors had but were overlooked or forgotten. Discover this for yourself by reading in your LIBRARY.





FIG. 1. Patient fixating for distance



FIG. 2. Patient fixating for near with absence of convergence.

## NUCLEAR OPHTHALMOPLÉGIA WITH BIOPSY OF EXTRA-OCULAR MUSCLE

J. E. BRUMBACK, M.D. AND J. E. BRUMBACK, JR., M.D.

More and more, chronic progressive nuclear ophthalmoplegia is being considered an affection of the extra-ocular muscles rather than a neurological condition. The following report presents a case with biopsy of the superior rectus muscle.

### CASE REPORT

A 63 year old white male was first seen on February 5, 1959, at which time his best corrected vision was OD 20/50, OS 10/200. He stated that it had been noted by the military service in 1918 that his ocular movements were restricted. He had never been aware of this prior to that time. He had had one brief episode of diplopia, lasting one-half hour, ten years ago. He had never been able to wear bifocals because he could not move his eyes into position to use them, and since being presbyopic, had always used two pairs of glasses. There was no family history of oculo-motor disease; one brother, who was examined and operated upon for cataract, had perfectly normal motility.

Examination revealed bilateral cataract. There was no ptosis of either upper lid. The pupillary reactions were normal directly and consensual bilaterally. The movements of either eye were restricted but not entirely absent. The eyes could not be moved more than three degrees in any direction. On convergence, the motility was no greater. No increase in movement

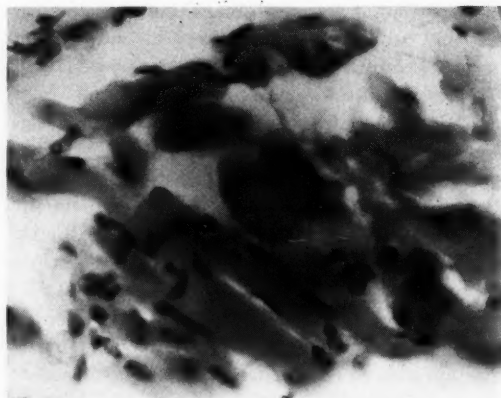


FIG. 3. Biopsy of superior rectus muscle, showing atrophy and loss of cross striation.

could be elicited on the optokinetic drum. On the Worth lights he showed alternate suppression with some preference for the right eye. A diagnosis of nuclear and cortical cataract was made, and on February 22, 1959 an intracapsular cataract extraction was performed on the left eye, under local anesthesia. At the time of surgery, the forced direction test of both eyes revealed definite resistance to movement in any direction.

Before proceeding with the cataract, the left superior rectus muscle was exposed and a portion excised for biopsy. This was examined by Dr. James

Duke, pathologist at the Wilmer Institute, who reported that it represented atrophic muscle tissue. There was hyalinization with loss of cross striation.

#### COMMENT

This patient probably represents an example of what has been called chronic progressive nuclear ophthalmoplegia. The complete absence of ptosis is unusual, as ptosis is usually the presenting complaint, but it can be absent without invalidating the diagnosis. This entity is now considered to represent a muscle abiotrophy rather than an affection of the oculomotor nuclei. This conclusion is based on the fact that lesions of the oculomotor nuclei (III, IV

and VI) have been found to be absent or minimal in this condition; whereas, pathologic changes in the muscles have been reported on numerous occasions.

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## MANAGEMENT OF TRAUMATIC HYPHEMA

ABRAHAM KREMEN, M.D. AND M. REZA HAGIGH, M.D.

Traumatic hyphema is a fairly common occurrence. We made a review of the patients admitted to the Baltimore Eye, Ear and Throat Hospital during the latter half of 1957 and the entire year of 1958. Twenty such patients were admitted from July 1, 1957 to December 31, 1957, and 34 were admitted from January 1, 1958 to December 31, 1958.

Traumatic hyphema occurs predominantly in juveniles and among males (tables 1 and 2). Thygeson and Beard, in reporting on a group of 34 cases, found 74 per cent below the age of 12.

Among the causes of traumatic hyphema are a wide variety of blunt objects, and BB shots stand

out prominently. One case occurred from a fall and five cases occurred from violence (table 3).

Most of the cases at the onset appear trivial and show a small amount of blood in the anterior chamber, a heavy ray with no gross blood, or a small clot on the iris surface. In the great majority, the blood absorbs promptly without any sequelae, but where secondary hemorrhage occurs, the end result can be disastrous.

To explain the anatomical basis for different clinical behavior of these traumatic lesions, we briefly mention the vascular pattern of anterior uveal tract. Iris vessels form the bulk of the iris and run

TABLE 1  
Sex Incidence in 1958

Sex	Number	Per Cent
Males.....	29	86
Females.....	5	14
Total.....	34	

TABLE 2  
Age Groups in 1958

Age	Number	Per Cent
4-17.....	19	56
18-30.....	8	23
31-45.....	5	15
Over 46.....	3	6

TABLE 3

Cause of hyphema in 34 cases in 1958	Number
BB shot.....	6
Violence.....	5
Toys.....	4
Ball.....	3
Stone.....	3
Unknown.....	3
Gun.....	2
Stick.....	2
Fall.....	1
Bottle.....	1
Whip.....	1
Snowball.....	1
Metal.....	1
Belt Buckle.....	1

radially in the tissue. Near the pupillary border and at the root of the iris are the minor and major vascular circles of the iris. Wolff states that at the pupillary margin the vessels are arterial and venous, but at the root of the iris the vessels are arterial and lie actually in the ciliary body in front of the circular portion of the ciliary body. Kilgore made experiments in monkeys on traumatic hyphema and demonstrated tears in the vessels in the ciliary body and separation of the ciliary body from the sclera.

We believe that when the hyphema results from injuries to the vessels of the minor circle of the iris or from the radial vessels of the iris, the blood absorbs promptly in two to three days without secondary hemorrhage. Every ophthalmic surgeon encounters anterior chamber hemorrhages occasionally after intraocular operations, and, in the vast majority of cases, these hemorrhages absorb promptly without sequelae. Immediate bleeding occurs from the iris vessels, but delayed bleeding most often occurs from the granulation tissue activity at the site of the section. The point is that in hemorrhages associated with surgery secondary glaucoma is rarely encountered. Therefore, we believe that where secondary hemorrhages do occur, the torn vessels are at the base of the iris or in the region of the ciliary body. Clinically the vast majority of secondary hemorrhages in the anterior chamber are accompanied by hemorrhages in the vitreous of varying severity.

Of the 20 patients with traumatic hyphema admitted during the latter half of 1957, seven developed secondary hemorrhage, an incidence of 35 per cent. Of the 34 patients during the year 1958, seven

developed secondary hemorrhage, an incidence of 20.6 per cent. The difference indicates that during 1958 all patients showing blood in the anterior chamber were admitted immediately, instead of treating the case ambulatory when the hemorrhage appeared slight.

Secondary hemorrhage occurs two to five days after initial injury. Of the seven cases of secondary hemorrhage in the 1957 series, five patients developed secondary glaucoma. Where operation was done in this group, the surgery consisted of paracentesis of the anterior chamber, followed by air injection. The results were poor and all cases developed blood stain of the cornea. All were discharged with elevated intra-ocular pressure, and the end visual results are not available.

Of the seven cases of secondary hemorrhage in the 1958 series, six developed secondary glaucoma. It was our observation that in these cases of secondary glaucoma, the hemorrhage entirely filled the anterior chamber. In the one that did not develop secondary glaucoma, the hemorrhage did not fill the anterior chamber. Four of the patients were operated on by the method to be described. One patient was operated on 24 hours after the secondary hemorrhage, and vision of 20/30 was obtained; the second patient was operated on within 48 hours and obtained 20/15 vision. The third patient was a child of 18 months, who was operated on four days after onset, and vision was not obtained. The last patient was operated on after five days; the resulting vision was light perception. In the remaining two patients, the hemorrhage from the anterior chamber absorbed but had considerable vitreous hemorrhage and elevated tension.

The management of secondary hemorrhage with secondary glaucoma presents a difficult problem. It is our opinion now that these patients should be handled as an acute surgical problem. Conservative treatment with the use of carbonic anhydrase inhibitor does not lower the intra-ocular pressure to a safe level. The clot becomes organized rapidly and blocks off the filtration angle of the anterior chamber. With persistence of elevated intra-ocular pressure, blood stain of the cornea takes place. In our observation, a small paracentesis to relieve the pressure or a paracentesis combined with an air injection is of little value. This was the method of treatment in the 1957 group. We have come to the conclusion that a wide intracorneal section should

be made surgically and the blood removed by irrigation from the anterior chamber or by milking the cornea to force out some of the clot. It is hazardous to insert instruments blindly into the anterior chamber to remove clots except where clots present or where clots can be seen and extracted without damaging the cornea or the lens. The corneal wound is then sutured firmly with two or three six-O silk sutures, and air is injected into the anterior chamber. On occasion one notices a continuous ooze from the iris root or region of the ciliary body. It is best to close the wound and inject air into the anterior chamber.

Because the most trivial hyphema may produce a secondary hemorrhage, we feel that all patients should be immediately hospitalized and ordered absolute bed rest with binocular occlusion, sedation, with record of intake and output of fluid, and strict limitation of visitors. Of the 34 cases in 1958, 25 cleared with no secondary hemorrhage and resultant vision of 20/30 or better. Two patients were found to have extensive vitreous hemorrhages after the hyphema absorbed. The other seven patients have been described. Duration of hospitalization for uncomplicated cases was three to ten days; for complicated cases, seven to 24 days.

#### SUMMARY

(1) All patients with traumatic hyphema should be hospitalized immediately and ordered absolute bed rest and binocular occlusion.

(2) Secondary glaucoma associated with secondary hemorrhage is an acute surgical condition, requiring

prompt treatment consisting of a wide intracorneal section, removal of as much blood and clot as possible by irrigation without blind instrumentation; closure of wound and air injection.

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(Dr. Hagigh)

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#### N. D. T. I.

Dr. Gunnar Gundersen, immediate past president of the American Medical Association, has accepted membership on the Medical Advisory Committee of the National Disease and Therapeutic Index (N.D.T.I.) medical statistical research program. The N.D.T.I., with headquarters at 8600 Prospect Avenue, Philadelphia, Pa., was organized four years ago to fill the need for a continuous flow of up-to-date, factual information on the illnesses, injuries and other conditions for which patients see doctors, and the treatments which they receive. Currently, some twelve hundred doctors participate in the program annually, providing important data for use in research and education. A similar program has been established recently in Germany, and others are planned in Canada, Great Britain, France and other areas in the near future.



# POLYCYTHEMIC CONJUNCTIVITIS

HENRY B. WILSON, M.D.

Polycythemia vera is not often seen by the ophthalmologist; yet, I believe he is frequently the first person to see patients afflicted with this disease. Polycythemia can affect almost any part of the body, due to vascular occlusions and engorgement. It causes symptoms ranging from crackling in the ears to dermatitis and especially congestion of the conjunctiva. It is much like diabetes, in that it affects the eyes consistently and early in its course. I came to this conclusion after seeing the patient in the following case history:

A white, married woman, age 49 and apparently in good health, first came to my office November 5, 1955, complaining of persistent inflammation, burning and mattering of her eyes for seven months. This had been treated with zinc sulfate drops, artificial tears, antibiotic drops, cortisone suspension and other local medications. These had not helped.

Examination of the eyes showed them to be essentially normal except for injection of the deep vessels of the conjunctiva, especially over the bulbar area. Schirmer's test and corneal sensitivity were normal. The cornea did not take a stain. Watching television and washing clothes caused the eyes to become more inflamed, but refraction was normal. Patch tests to various soaps were positive, but Pyribenzamine® did not help the conjunctivitis. Culture and smear were negative except for the usual flora of *Staph. albus* and *Neisseria catarrhalis*. She gave a history of a rash of the legs for about six months. Medical consultation was requested.

The medical examination revealed scaliness, excoriations, papules and pustules of the inner surface of the thighs, but otherwise it was negative. Laboratory studies disclosed the hemoglobin to be 21.5 gms.—hematocrit 65 per cent—red blood cell count 7,430,000—blood sugar, cholesterol, and white blood cell count normal. Tuberculin and toxoplasmin tests were slightly positive. This was at first thought to be due to hemo-concentration, since there were no other signs of polycythemia. The test was repeated, and diagnosis of polycythemia vera was made by Dr. John Parsons. Treatment by bleeding and radiative phosphorus was begun at Johns Hopkins.

The eyes immediately became much less injected and were comfortable. The skin eruption cleared. After treatment the patient's complexion became

paler. She later reported a conjunctival hemorrhage occurred in 1956. In 1957 a few small retinal hemorrhages were found. These were no longer present six months later. The retinal vessels were never engorged except on one visit in 1956. The large conjunctival vessels have been normal, but slit lamp examination showed the microscopic vessels were slightly dilated after treatment was begun. Since treatment for polycythemia the patient has had no complaint in regard to discomfort of her eyes and has felt well in general.

The first case history reported in the literature was by Louis Vaquez in 1892. This patient was described:

"When we examine him we find that we are dealing with a man afflicted with a chronic cyanosis, without a trace of edema, with considerable dilatation of the veins, with an intense redness of the face, marked injection of the conjunctiva, the whole caused probably in the absence of any other plausible hypothesis, by a congenital lesion of the heart which in any event does not give any certain sign on auscultation. Examination of the blood made by us at this time showed the surprising figure of 8,900,000 red cells, that of the white cells remaining practically normal for this proportion."

All four of the cases which Sir William Osler first described in 1903 had injection of the conjunctiva, and in two of them the injection was noted as the most prominent aspect of the general cyanosis.

In addition to conjunctival injection, other ocular symptoms of polycythemia described by Walsh are dilatation of the retinal veins, perivasculitis of the veins, retinal cyanosis, optic neuritis, papilledema, optic atrophy, retinal hemorrhage, spasm of the arteries and occlusion of the arteries and veins. Amaurosis fugax is a frequent premonitory sign of vascular occlusion.

In general, these symptoms are much less common than conjunctivitis and appear later in the disease. Except in one case with retinal engorgement, none of the above symptoms were first described by Vaquez or Osler.

Engorgement of the retinal vessels often may not occur because of the vasomotor instability which sometimes results in constriction of the blood vessels.



The diagnosis of polycythemia is much more difficult for the ophthalmologist than is the diagnosis of diabetes, due to the differential diagnosis. The differential diagnosis of chronic conjunctivitis due to internal causes is long and interesting. A brief outline may be helpful:

- I. Disorders of environment
  - a. Smoky atmosphere
  - b. Intense sunlight
  - c. Constipation
  - d. Alcoholic indulgence
  - e. Hay Fever
- II. Disorders of adjacent structures
  - a. Lid infections
  - b. Lacrimal sac infections
  - c. Orbital infection
  - d. Sinusitis
  - e. Intracranial arteriovenous aneurism
  - f. Other causes of increased venous pressure
- III. Parinaud's Oculo Glandular Conjunctivitis
  - a. Leptothrix
  - b. Tularemia
  - c. Tuberculosis
  - d. Syphilis
  - e. Lymphogranuloma venereum
  - f. Sporotrichosis
  - g. Glander's bacillus
  - h. Pseudo tuberculosis rodentium
  - i. Soft chancre
  - j. Vaccinia
  - k. New Castle disease
- IV. The Oculo Muco Cutaneous Syndrome  
(Reiter's Syndrome, Steven's Johnson disease, Erythema multiforme and others)
- V. Conjunctivitis Associated with Skin Diseases
  - a. Local spread such as lupus erythematosus
  - b. Pemphigus
  - c. Rosacea
- VI. Phlyctenular Disease
- VII. General Vitamin Deficiency (usually in very young and very old and war prisoners)
- VIII. Telangiectasia
  - a. Congenital
  - b. Associated with arteriosclerosis, diabetes, Addison's disease
- IX. Endocrine Diseases
  - a. Gout
  - b. Sjogren's Syndrome

#### X. Cyanosis of the Conjunctiva.

There are many other causes for cyanosis of the conjunctiva besides polycythemia, but polycythemia vera is probably the main cause. Cold and dampness increase the cyanosis.

The results of treatment of polycythemia vera are good, although the long term results are far from ideal. Both the patient described and another patient of mine who has been under treatment many years have no symptoms and are doing very well. On examination they show only injection of their conjunctival vessels, and this is not seen without a microscope.

The cause of polycythemia vera has not yet been found, but there has been much recent work. Several factors enter into the formation of red blood cells such as vitamin B-12, folic acid, copper and erythropoietin. Dr. Leon Jacobson, in the Alice Band lecture of 1959, described some of the actions of erythropoietin and showed the probable source to be in the kidneys. This may explain the occurrence of polycythemia with some hypernephromata. The association of leukemia with polycythemia also seems significant.

The point is many patients with polycythemia complain of conjunctivitis and they may be seen first by an ophthalmologist. Although the ophthalmologist may believe cyanosis is present he obviously needs the help of a thorough general examination.

6 East Eager Street  
Baltimore 2, Maryland

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1. Innerfield, I.: Clinical report cited with permission

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## CASE SELECTION FOR KERATOPLASTY

RICHARD E. HOOVER, M.D.

Corneal transplants may be divided into two types: those penetrating the full thickness of the cornea and those which include only a partial thickness of the cornea. The first are known as penetrating keratoplastys, or corneal transplants, and the second are called lamellar keratoplastys. The penetrating transplant may be of any size but generally is six to nine mm. in diameter. There are occasional indications for smaller sizes and, in an occasional desperate case, for larger sizes, when it can include the entire cornea and even a small scleral segment. The lamellar transplant may be of any design or size and may also occasionally include a scleral segment.

A further distinction are those done for visual improvement and those done as therapeutic measures. There are times when both considerations are important.

In general, penetrating transplants are performed for the purpose of improving visual acuity, and lamellar procedures are employed for therapeutic reasons; i.e. to abolish or reduce symptoms, to promote healing, to cover threatening and complete perforations and/or to promote healthier host tissue for a penetrating transplant.

There are many exceptions to these general indications. For instance, a penetrating keratoplasty may be employed in abscesses, perforations or any other pathological process where the first consideration is salvation of the globe and the visual result becomes secondary and where the entire corneal thickness, including Descemet's membrane and endothelium, are involved, e.g. a large corneal abscess.

Conversely, lamellar keratoplastys are at times indicated where improved visual acuity is the prime objective, even though the visual result is not expected to reach the level one might possibly obtain from a penetrating keratoplasty. This is especially true of certain corneal scars, superficial vascularization and pathological processes, where the risk of losing the eye might be considered greater than the acuity difference gained. This could be especially true of one-eyed patients and in certain aphakic individuals.

If the keratoplasty is solely for increased acuity, then other considerations come into their proper perspective and have to be carefully evaluated to determine if the remainder of the media, the retina

and the nerve are functionally capable of allowing a good visual result, providing the keratoplasty is a success. This means that the cornea must be in a reasonably healthy state, especially the periphery of the bed, which must nourish the graft, without too extensive vascularization and without too much in the way of a pathologically active process at the time of the transplant. It also means the lens and vitreous must be reasonably clear. It would not be a complete visual success if there was known retinal disease which prevented good vision even if the graft were to remain clear. Therefore, if the retinal pathology is known to cut the vision below the level at which keratoplasty is to be done, it would be useless and unnecessary surgery to pursue this course. Optic nerve pathology can also reduce the potential visual result. If the lens is cataractous, then cataract extraction is generally best performed several months after the successful clear graft, especially if a penetrating graft is to be used. If a lamellar is to be attempted then aphakia does not present this problem.

There are exceptions to indications for each type of keratoplasty. Many times, even though the keratoplasty is being done for visual reasons, the lamellar may be the proper choice. This could be true if visual requirements do not need to be of an extremely high level and the chance of eye damage from the penetrating surgery would seem to carry some unnecessary risk.

In general, it is better to do lamellar transplants even for visual results when there is extensive vascularization present; also when the opacity or pathology is mainly superficial and where reasonable visual levels can be expected regardless of the type of procedure. Penetrating keratoplastys are, on the other hand, sometimes indicated even where there is a therapeutic result desired. This is true when the entire corneal stroma, including Descemet's membrane and endothelium, is involved.

In general, lamellar keratoplastys should be of large diameter, and penetrating keratoplastys should be of small diameter. The type and size will vary with individual cases and may often be just the reverse of the general practice and procedure.

Penetrating keratoplastys seem to produce the best result in such pathological processes as kerato-



conus, certain types of familial dystrophies and in localized central opacities without much surrounding corneal pathology or vascularization. They may also be indicated in Fuch's endothelial dystrophy.

Lamellars are generally used in superficial processes, such as herpetic or metaherpetic lesions, certain infections of the cornea, perforations of the cornea from ulcers or wounds, and for recurrent erosions either primary or secondary to other pathology.

The visual acuity level at which it is decided to do a transplant varies with age, need, pathology and condition of the second eye. When the chance of success is great, as it is in keratoconus, certain familial dystrophies and certain central scars, and where there is need of exceptionally good acuity in at least one eye, the surgeon may be somewhat more dashing and perform surgery at levels of 20/50 or 20/70, which would under other circumstances be considered risky even at a 10/200 or 15/200 level.

One cannot write concerning corneal transplants without a word of caution and mention some of the rather common complications.

Penetrating keratoplasty involves opening the eye and is fraught with all the hazards and dangers of any penetrating wound. These dangers have been greatly minimized in the past few years. Any penetrating wound to the eye carries a small threat of sympathetic ophthalmia and also carries a small possibility of infection. Both have become less common and less to be feared in recent years, since surgical techniques and newer methods of therapy have been introduced.

Other complications such as anterior synechiae, lens damage, a persistently shallow chamber, secondary glaucoma, vascularization and late clouding of the graft still occur in about the same proportion as in past years. With the introduction of better surgical instruments, suture materials and techniques, these complications are expected to be reduced and no longer are these procedures feared as in the past.

Some of the conditions influencing late vascularization and clouding of the cornea we do not entirely understand, and we are, therefore, at a loss in many instances to prevent or reverse them.

Lamellar keratoplastys do not involve the obvious risks a penetrating transplant does unless there is planned or accidental perforation.

It is not unknown to have secondary glaucoma, infection, sloughing of the graft, vascularization and opacification of the graft even in this type of procedure. However, these complications are all much less frequent in the lamellar than in the penetrating.

Sometimes a simple keratectomy will give the same therapeutic and visual result as will a lamellar keratoplasty. Also, some of the indications which once called for keratoplasty, when these have been the cause of poor vision, are now very many times more satisfactorily remedied by fitting with the proper contact lens.

Many of the indications which previously had called for conjunctival flap are now being considered for keratoplasty, and it is probably fair to state if a conjunctival flap is therapeutically indicated, proper corneal tissue, if available, will do the job as well, and in most instances better, with the same therapeutic result and always a better visual result.

Donor material is still a problem in some areas where eyes are not available. The eye banks over the country are making a great effort to supply all surgeons who do corneal work with the number of donor eyes they require. Many of the hospitals are now including in their request for autopsies the need for donor eyes, and this has added an available source of transplant material.

There are methods of preservation and freezing which have been written about and discussed but are still in the embryonic phase and not available for everyday hospital or clinic use.

The very young eye and the very old eye are, in general, not as acceptable for donor material as the eye of the middle aged individual with no previous ocular disease and in good health.

The length of preservation of the donor material varies, again depending on the type of keratoplasty to be performed. If a penetrating keratoplasty is to be performed, the sooner the eye can be used the better; in general, it is best not to wait more than 48 to 72 hours after the eye has been enucleated before it is used as donor material.

In the lamellar grafts, where the need is therapeutic and not necessarily visual, a longer period of time can pass before the donor material is used.

*14 West Mt. Vernon Place  
Baltimore 2, Maryland*



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## Letters Of Interest

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Mr. M. L. Harney  
Superintendent  
Division of Narcotic Control  
Department of Public Safety  
1012 Myers Building  
Springfield, Illinois

Dear Mr. Harney:

I enclose copy of the United Nations Bulletin on Narcotics, January-March 1959 issue, containing an article entitled "Drug Addiction in the Medical and Allied Professions in Germany" by Dr. H. Ehrhardt, President of the German Society for Psychiatry and Neurology.<sup>1</sup>

In the light of present agitation to turn drug addiction back to the medical profession this contribution is timely indeed. The article describes the so-called European system which the committees of the ABA-AMA group pointed to as being an ideal solution for the problem in the United States.

The number of drug addicts in the Federal Republic of Germany in 1957 was 4,861, all obtaining narcotics from medical supplies. Astonishing is the fact that 20 per cent of the number of addicts are in the medical and para-medical professions. There is no smuggling of narcotic drugs. It points up very sharply the fact that by turning addicts over to the medical profession the situation is out of control.

Dr. Ehrhardt makes the very frank statement "we must therefore assume the existence of a hidden number which can hardly be estimated."

The medical profession of the State of Illinois, which is cooperating with you so whole-heartedly, will be intensely interested in this brilliant study.

The article is irrefutable proof that the policy being pursued in the United States, that is (1) compulsory treatment of the addict in closed institutions and (2) heavy penalties for the trafficker, is on a firm foundation as evidenced by the unanimous support of Congress and all of the state legislatures.

Fred Sondern will have an article "Let's Face Our

<sup>1</sup> Bulletin on Narcotics, United Nations, Vol. XI, No. 1, Jan.-Mar. 1959.

June 9, 1959

Narcotic Problem Sensibly" in the forthcoming issue of The Reader's Digest.

Sincerely yours,  
H. J. Anslinger  
*Commissioner of Narcotics*

July 24, 1959

George H. Yeager, M.D., Editor  
Maryland State Medical Journal  
1211 Cathedral St.  
Baltimore 1, Maryland

Dear Dr. Yeager:

The Medical and Chirurgical Faculty of the State of Maryland (Maryland State Medical Association) has, for many years, expressed concern over the inroads the Veterans Administration Hospitals are making into the realm of the private practice of medicine. In order to combat the fantastic growth of treatment of non-service connected ailments of veterans, the Faculty has passed many resolutions condemning this practice and urging that something concrete be done to curtail or stop this insidious growth.

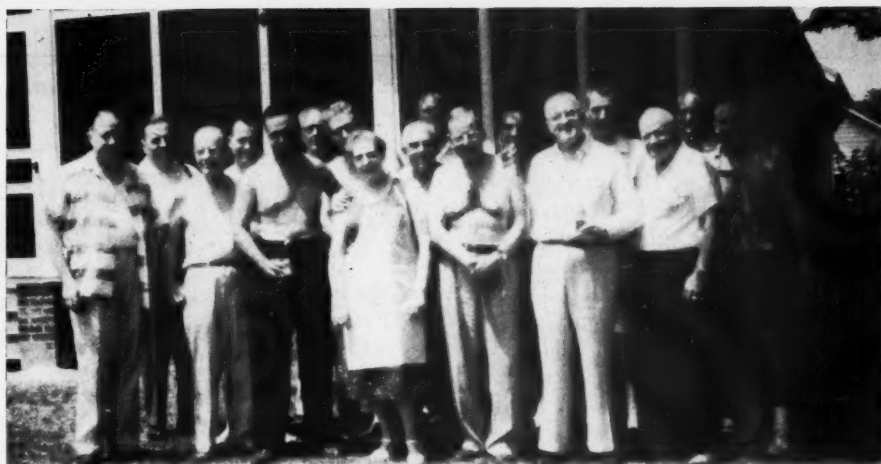
The Faculty's House of Delegates at its 1959 Annual Meeting passed a resolution that all component medical societies of the American Medical Association be contacted and urged to support the Faculty's stand in this respect.

As a result of a letter sent to every A.M.A. component medical society, eleven answers have been received all in the affirmative.

It is anticipated that other societies will also reply in the affirmative and that full support to this projected concerted action will be forthcoming from them as well.

I sincerely hope that you will see fit to publish this letter and alert your readers to the steps that are being contemplated along these lines, not the least of which is the hope that an appropriate resolution will be introduced in the A.M.A.'s House of Delegates at its clinical session in Dallas in December.

Sincerely,  
Amos R. Koontz, M.D., *Chairman*  
Committee on Veterans' Medical Care



Shangri-La and those present: Left to right—Drs. J. Sheldon Eastland, Edward Ditto, Jr., Howard M. Bubert, William Carl Ebeling, Russell H. Fisher, Leo Brady, R. Walter Graham, Mrs. Anna Wynde Leake, Dr. Albert Goldstein, Mr. Walter A. Kirkman, Drs. Wetherbee Fort, Robert vL. Campbell, Amos R. Koontz, Howard F. Kinnamon, Leslie E. Daugherty, Waldo B. Moyers, Mr. John Sargeant. Also present, but not pictured, were Drs. Karl F. Mech, William A. Pillsbury, Charles F. O'Donnell and Philip Briscoe.

## THE JUNE COUNCIL MEETING

(Photos and commentary by Leslie E. Daugherty, M.D.)

Tuesday, June 30 was no ordinary day. The temperature in Baltimore was 102 degrees. The sky was full of clouds. The councilors were full of energy, and everyone was anxious to see Wetherbee Fort's Shangri-La.

By stationwagon, automobile or boat, we converged on Fort's Hideaway. The refrigerators were loaded with refreshments of every kind. Wetherbee proved an excellent host. Nearly everyone took a swim in the waters of the Patuxent. By two o'clock everyone was hungry and could have eaten an ox. Well—we did eat part of an ox; sizzling steaks browned over a charcoal fire.

Appetites satisfied, the councilors met and in short order took care of the official business brought before them.



Some came by boat



Everybody had a hand in it



Some liked their steaks well done

Others liked them well served

A swim in the Patuxent was refreshing.



So were the ice-cold beverages



## In Memoriam

*Edward I. Lederman, M.D.  
1914-1958*

The medical profession of this state was shocked and grieved at the sudden death from coronary thrombosis of Dr. Edward Isadore Lederman on June 7, 1958. Although only 44 years old, he had already established a distinguished record for himself.

Born in Cleveland, Ohio in 1914, the son of Samuel and Yetta Lederman, he received his early education in Cleveland. In 1941 he received his medical degree from the College of Medicine, University of Cincinnati. In 1942 he was married to Roberta Rosenthal, the daughter of Sidney and Hilda Rosenthal. He then interned at the Baltimore City Hospitals. In 1942 he was commissioned as a First Lieutenant in the Medical Corps of the U. S. Army, and served in the United States and in New Guinea.

He returned to the civilian practice of medicine in 1947. Since then he followed the specialty of his choice, anesthesia.

As one who had the privilege of knowing him in the Army when he served in the Southwest Pacific theatre of operations and later in civilian practice, I feel impelled to add a few words to what is already known to Ed's many friends. He was a man of high ideals and quiet courage, and he demonstrated these traits in the challenges of both combat and peace.

On July 14, 1944, soon after the assault and capture of the Japanese occupied island of Biak, off the northeast coast of New Guinea, he was awarded on the field the Silver Star by Brigadier General Doe, commanding general of the 41st Infantry Division.

The citation for this award reads:

"Captain Edward I. Lederman, (0417134), Medical Corps, United States Army. For gallantry in action at Biak Island on 28 May, 1944. Captain Lederman was the assistant surgeon of an Infantry battalion engaged in combat with a determined group of enemy located in advantageous position on high ridges. Several casualties were incurred putting a strain on the facilities of the battalion aid station. Captain Lederman therefore, moved forward to advance units to render medical assistance with less delay. Under severe fire, he gave medical assistance to the wounded and expedited their evacuation to the rear. During the withdrawal from the position across an open beach, he stopped to aid a severely wounded man. These outstanding acts of Captain Lederman required a great deal of courage and initiative and the results of his work saved the lives of many soldiers."

This action took place when the Japanese permitted the U. S. Infantry Battalion to which Ed was attached to pass along a rough beach road, withholding their fire from emplacements in coral caves overlooking the road. Suddenly the Japanese attacked from the rear, throwing down a road block and firing from the caves on the isolated battalion, which was eventually rescued by amphibious craft called "alligators." The fiercest sort of fighting took place. I visited the area soon after, in my capacity as surgical consultant, and learned more of the details of the fight and of Captain Lederman's heroic actions. He seemed to be everywhere, administering to the wounded; so pressed was he for emergency equipment that at the end of the fight he himself had no belt and no shoe laces, having used them for tourniquets on the wounded.

It is, therefore, not surprising to learn of Ed's consideration for his patients in civil practice. His continuing battle was to see that the patient received the best care. In the struggle to overcome what he considered to be unethical standards in anesthesiology, he was the leader. He made it a rule to see every patient not only the day before operation, but every day after operation, until all danger of complications seemed over. His skill in his chosen profession was recognized by all. The surgeon lost all his anxieties about anesthesia when working with Ed. Greatly interested in hypnosis, he had for three years been experimenting with its use in preoperative and postoperative cases.

As might be expected, his cheerfulness and keen sense of humor were outstanding qualities. For hobbies he enjoyed fishing and gardening.

Ed was a devoted husband and father. To his wife, Roberta, to his three children, Judith aged 14, Richard aged 10, and Tommy aged 7, goes the deepest sympathy of this Faculty. We share with them their grief and we share with them their solemn pride in having such a husband and father.



I. Ridgeway Trimble, M.D.

# Component Medical Societies



## ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*

### CUMBERLAND MEMORIAL HOSPITAL STAFF LUNCHEON

An increasing demand on the physician's time has lessened attendance at County Medical Society meetings throughout the County. Local Hospital Staff meetings, while not taking the place of Medical Society Meetings, never the less have lessened the desire on the part of many physicians to attend more Medical Meetings than are absolutely required.

To obtain hospital privileges the following staff regulation is a part of nearly all By-Laws and Constitutions:

... All members of the active Medical Staff shall be required to attend meetings of the Medical Staff. Absence from one-fourth of the regular meetings for the year, without acceptable excuse, shall be considered as resignation from the Medical

Staff and shall automatically cancel the member's hospital privileges. . . .

Whether it is right or wrong, sooner or later physicians must decide what is a proper amount of time to devote to each. Evaluation of required services is in order by Component Medical Societies.

Fringe benefits play an active role in Hospital Staff activities and may be some inducement to regular attendance. Clinical conferences hardly take the place of good clinical programs conducted by Component Societies and a continued search for good speakers on timely subjects, with fringe food benefits are always to be kept in mind. Business at social meetings should be kept at a minimum. Those problems that require approval by the entire Society, should be brought before it at a closed business meeting.

### NEW PHYSICIAN LOCATES IN FROSTBURG

Dr. Alvin J. Walters, nephew of Dr. Hilda Jane Walters, of Frostburg, has opened an office there for the practice of general medicine and surgery.

He was born in Lynchburg, Virginia, and spent his childhood in Iowa, where he attended elementary



Memorial Hospital, Cumberland, Md.



Smorgasboard



Good Food and Refreshments



and high schools. He pursued his premedical and medical studies at Iowa University, Iowa City. He was graduated in 1954 and interned at Mercy Hospital, Baltimore, where he also took postgraduate work in surgery. He also studied at the Veterans Hospital in Little Rock, Arkansas. Dr. Walters is married to the former Vivian Walter, of Burlington, Iowa. They have four children.

#### PERSONALS

Dr. Thomas F. Lewis, Cumberland, addressed the Sacred Heart Alumnae Association, when the Hospital School of Nursing entertained the 1959 graduates with a dinner and dance recently.

Approximately 40 office assistants of Allegany County physicians were present at a dinner meeting with representatives of the Maryland Blue Shield, held at the Fort Cumberland Hotel, in Cumberland on September 10. Mr. Denwood N. Kelly, assistant director of the Blue Shield Plan led the discussion, and a question and answer period followed.

Dr. Abdul S. Hashim, Cumberland physician and a native of Iraq, spoke on "Social Progress in Iraq" at a luncheon meeting of the Cumberland Rotary Club.

### FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

*Journal Representative*

In August we were saddened by the loss of one of our most noted members. On the evening of the 25th, after working at his office, Dr. Eddie Thomas died suddenly. The notables from Baltimore who attended his funeral were Dr. C. Reid Edwards, Dr. W. H. Toulson, Dr. Robert Johnson and Dr. Harry C. Hull. The Frederick County Medical Society attended as a body.

Our roll was increased by two this summer. The first to come was Dr. Richard C. Reynolds, an internist and a graduate of Johns Hopkins, Class of 1953. He spent four years at Hopkins as intern, resident and fellow and two years as a Public Health Officer in Alaska.

In late August Dr. Adel Demiray arrived. He is a graduate of the University of Istanbul, 1950. He interned there and spent the next six years training

in surgery at Wichita and Kansas City. Most recently, he had practiced general surgery at Galax, Virginia. We welcome these well trained men and wish them happiness and success.

Another event of note was the opening of a medical building on Toll House Avenue. Actually, it is a medical village, consisting of five separate one story buildings. They are occupied by Drs. Heldrich, Powell, Brinkley, Lea, Demiray, Reid, Campbell and Fifer. Dr. Furie has opened a branch clinical laboratory there. Mr. Russell Fisher practices physiotherapy in a similar suite. A pharmacy is located in the building closest to the street. The buildings, of brick and redwood, form a semicircle about a large green lawn. After they acquire the patina of age they will be quite handsome.

### MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.

*Journal Representative*

Jacob W. Bird, M.D. has been honored warmly by his colleagues, friends and patients upon completion of his fiftieth year of medical service. Two pages of photographs and praise were devoted by a Washington newspaper to the "Family Doctor for 50 Years." Doctor Bird's contributions through the Montgomery County General Hospital have been appreciated by thousands of people.

**Dr. Charles Robert Lee Halley married Adelaide Bristol Satterwaite.**

Dr. J. Norman Kimble, past president of our Montgomery County Medical Society and director of radiology at Washington Sanatorium and Hospital for 27 years, died. He will be missed by all of us who knew his friendly manner and clinical astuteness.

The Physicians Directory has been prepared with care and contains bibliographic data and photographs of our Society's members. Representatives of pharmaceutical organizations have welcomed enthusiastically the Directory and contributed their part to its success. Deserving extra credit for the Directory are Doctors DeWitt DeLawter, for central responsibility; John Robben, Allen O'Neill, and William Aud, for encouraging membership participation; Stephen Jones and Ralph Carbo, for the advertising program. As in practically all successful

ventures of our Society, the able efforts of our executive secretary, Mr. John W. Loy, have made themselves evident.

The Medical Bureau and Exchange is now a going concern. Answering our doctors' telephones is a demanding and continuing responsibility; the ladies who serve as operators are learning and correcting their mistakes as we all press on to greater achievements of the future. There seems little doubt that the supervision we can give, both as physicians and owners, has contributed to the improvement in

telephone answering courtesies and care, on which many patients have made complimentary remarks.

The medical planning for disasters has progressed apace with Dr. Merrill Cross' ably pioneering community relations. Several recent tragedies and near disasters have alerted all of us to the question, "What would I do medically in that disaster?" Chiefs of police and fire departments seem to be learning the quickest and best way to obtain expert help for disaster victims is to call the Montgomery County Medical Bureau.

#### ETHICS CORNER

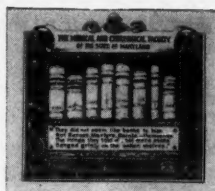
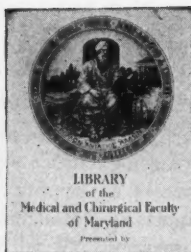
*Editor's Note: Queries regarding ethical problems are received from time to time in the Faculty office. In many cases, these queries deal with situations that arise almost daily in the practice of medicine. In other cases they are extremely unusual situations which would not occur again for many years. In an attempt to acquaint the membership of the Faculty with some of the answers to these everyday situations, this new ETHICS CORNER is being instituted. If you have a question on ethics to which you would like an answer, direct your inquiry to the Editor, Maryland State Medical Journal.*

Many requests are received in the Faculty office relative to a physician who wishes to dismiss a patient because of a clash of opinions or because of apparent lack of confidence by the patient in the care being rendered by the physician.

Freedom of choice of physician also carries with it the freedom of choice *BY* the physician to accept an individual as a patient or to reject him. The Judicial Concepts of the American Medical Association clearly states, "... This the Council interprets to mean not only the patient's right to choose any physician desired but also, conversely, the physician's right to accept or reject any patient requesting his services ..." and also, "... Therefore, the physician whom the patient chooses may decline to serve when he is chosen, or the chosen physician may be unavailable for many reasons."

In many instances, the physician is concerned over the best manner in which to discharge a patient. A physician should notify the patient, preferably in writing, that because of the situation he would prefer not to continue rendering treatment to him. He should make the offer to provide a history or the medical records of the patient to any other physician the patient may choose. He should also state a time limit as to when his services will cease and be quite explicit about this cutoff date.

In any event, a physician should always render care in case of an emergency and continue to render care until the patient or his relatives can provide the services of another physician.



## Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves,  
thy pleasure-nooks and gardens." *Ibn Tibbon*

BLOW, BUGLE, BLOW, SET THE WILD ECHOES FLYING,  
AND ANSWER, ECHOES, ANSWER, DYING, DYING.

Tennyson

It is not our nature or our inclination to "blow our own horn," but the time has come when we feel it expedient to do so for the enlightenment of our members.

For many years libraries were but a storehouse for accumulated knowledge. This is no longer true, not only because of change in policy in managing libraries, but also due to the awakening of peoples of the universe to their use and to the advent of universal education. Our great public libraries serve a dual purpose, education and amusement; our special science libraries are essentially educational in scope. This is particularly true of all medical libraries which cater to a small percentage of our population.

Bearing the above facts in mind, it is ridiculous to compare the usage of a medical library with that of a public one, or to pit the usage of a society library against that of a medical school, where much of the reading is done on a more or less compulsory basis, due to teaching, study and research projects. A library such as that of the Medical and Chirurgical Faculty is used mainly for postgraduate education or adult education and, as such, reflects the ability or desire of its potential clientele to keep abreast of the changing pattern of medicine, to refresh forgotten facts and to study the history of medicine, without which there would be no superstructure.

Now, how do you come into this picture? Ask yourself the following questions and you will find out:

1. Do I ever go to the library or have sent to me to look over, recent books and/or journals which I am unable to purchase?

2. Do I ever ask the library to assist me with literature on a specified subject or problem?

3. Do I ever ask the library for information relating to medicine or to my practice?

4. Do I ever use the library at all?

If the answer to the above is NO, then the criticism should be of yourself, not of the library.

We often wonder how a doctor would feel or, alas, may have felt, if a nurse or medical secretary or someone with whom he should work toward the betterment of his practice, made statements to him along the following lines: Medicine, as practiced by you, is of no value; it's out of date from year to year; or, Far more people go to the corner drugstore than those who consult physicians; or, Too much money is spent on medical education; little of it is remembered and hardly any of it used in actual practice, so it is a worthless expenditure of time and money. You would, most likely, brand such a person as ignorant, or else feel that he spoke out of pique or in ill humor; yet librarians constantly hear doctors make equally wild statements about medical libraries.

Your library is ready to meet you more than half way in your desire to perfect yourself in your chosen field, by offering you, no matter where in the state you live, the contents of a fine medical library and, if desired, the privilege of borrowing from the National Library of Medicine, the finest medical library in the world. In addition to this, our services include checking brief bibliographies, getting out books on a given subject, compiling short bibliographies, and answering questions too catholic in character to enumerate.

As we felt the library was not used according to its merits, we have instituted the pioneer project of taking small collections of new books and journals to

our county society meetings. Some counties have made no reply, but a few are enthusiastic enough to warrant our giving the extra time in the firm belief this phase of our work will grow in popularity and further cement the Faculty as a whole. In addition, through our page in the Maryland State Medical Journal, we have repeatedly asked for constructive criticism and suggestions.

Those members who read and keep abreast of the literature do use our services, as is attested to by the fact that we have had one member wait in another medical library while telephoning us for information on a reference before giving treatment; we have had men call us for information given weekly in their own copy of the Journal of the A.M.A., and it is our principal duty to assemble books and articles on a specified subject or to check the literature for similar cases before the member reports his own case. It is because we have been of service to some that we know we can be of more use to more men, did they

but realize it. Ignorance of our ability to help, should change the old saying "Where ignorance is bliss, 'tis folly to be wise." to read "Where ignorance is bliss 'tis folly..." If you have read thus far with an open mind, you cannot honestly say the library is no good, it's a dead weight, a storehouse of forgotten lore, but you can look facts in the face and know the fault is your own if you have not used our services.

Your library is one to be proud of and compares to its advantage with others of like size. The collection is sound because it has been chosen by your fellow members. Your Library Committee will be glad to discuss and listen to your suggestions. The staff believes in its work and will, accordingly, willingly do more than just its duty. We are all human, but a courteous request will be fulfilled to the best of our ability; the rest is up to you. We offer you the opportunity for a better knowledge of medicine through your library and dare to believe that as your usage increases, your criticism will decrease in proportion.

#### A.M.A. TO HOLD 13TH CLINICAL MEETING IN DALLAS

CHICAGO—The American Medical Association's 13th clinical meeting Dec. 1-4 in Dallas, Texas, will draw some 3,500 physicians, mainly from the southern and southwestern states.

Planned in cooperation with Dallas physicians, the meeting is designed to help the family physician meet his daily practice problems.

Dr. Everett C. Fox, Dallas, is general chairman of the meeting, while Dr. C. D. Bussey, Dallas, is program chairman.

Among the subjects to be discussed on the scientific program are soft tissue injury; whip-lash injuries of the neck; diabetes; heart murmurs in children; new laboratory procedures; new resuscitation techniques; premarital and marital counseling, and the problem child.

Dr. Hubertus Strughold, professor of space medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, will be principal speaker at the opening scientific session Dec. 1. Dr. Strughold, often called "the father of space medicine," will discuss the role of medicine in the space age.

The winner of the A.M.A.'s Distinguished Service Award at the Atlantic City meeting—Dr. Michael E. DeBakey—will participate in a symposium on the surgical considerations of cerebrovascular insufficiency Tuesday afternoon, Dec. 1. Dr. DeBakey, chairman of the department of surgery at Baylor University College of Medicine, Houston, was given the award for his outstanding contributions to medicine in the field of vascular surgery.

The scientific program, including lectures, symposiums, medical motion pictures, color television, and nearly 100 scientific exhibits, will be held in Dallas Memorial Auditorium. Industrial exhibits will number 251.

The auditorium will also house the "world's largest health fair," sponsored by the Dallas County Medical Society in conjunction with the A.M.A. The fair will run from Nov. 27 to Dec. 7 and will be open to the public.





## Maryland SOCIETY OF PATHOLOGISTS INC.

LOUIS B. THOMAS, M.D., *President*

EDWARD C. MCGARRY, M.D., *Secretary*  
Suburban Hospital, Bethesda, Md.



### THE A-B-C OF P.B.I.

*Protein Bound Iodine* determination is a measure of thyroxine and small quantities of other thyroid hormones in serum, and therefore is an indication of thyroid function.

*Normal Values* for the normal adult are between 4.0 and 8.0 micrograms per 100 ml. of serum. The newborn infant has levels somewhat greater than maternal levels. The infant levels gradually fall to the adult range at about one year of age.

*Pregnant Women* have values between 6.0 and 12.0 micrograms per 100 ml. There appears to be some correlation between the failure of a rise in value at about the sixteenth week and spontaneous abortion.

*Thyroxine Therapy* causes a slight elevation of the level of P.B.I. in normal individuals and pronounced elevation in severe hypothyroidism.

*Tri-iodothyronine Therapy* may cause a decrease in the P.B.I. level.

*In Hypothyroidism, Myxedema and Cretinism* the values are low. Low values have also been reported in debilitating diseases.

*Hyperthyroidism and Acute Thyroiditis* are characterized by increased P.B.I. levels.

*In Chronic Thyroiditis* the values are variable but often low.

*Malignancy of the Thyroid Gland* leads to variable values. Highly differentiated neoplasms are usually associated with elevated values, and poorly differentiated neoplasms are usually associated with low levels.

*Mercury Therapy* causes low values because this metal interferes with the chemical determination.

*Contact with Inorganic Iodine*, either as a therapeutic agent or as a contaminant, causes an artifactual increase in P.B.I. due to nonspecific binding of iodine to plasma protein. More than 300 pharmaceutical compounds contain iodine. Recently even one brand of nail polish was found to contain iodine. Syringes and containers free of iodine must be used to collect specimens.

*X-Ray Contrast Media* may interfere for as little as one or two weeks to as long as five years. One to two weeks: Hypaque®, Mediopaque®, Neo-Iopax®, Urokon®. One to six months: Diodrast®, Telepaque®, Priodax®, Skiodan®, Cholegratin®, and Skiodan®-Acacia. Up to five years: Pantopaque®, Lipiodol®, Visciodol®, Iodochlorol®, Ethiodol®, Salpax®. Certainly, other iodine containing contrast media will interfere.

*Butanol Extractable Iodine* determination values are approximately 1 microgram lower than P.B.I. values. The determination is more difficult to perform and is more expensive, but should be used if the patient is receiving inorganic iodine. It is not useful when the interference is due to x-ray contrast media.

*Thyrotropin Test* using protein bound iodine as an indicator may be used to differentiate hypothyroidism and hypopituitarism. Thyrotropin causes an increase of P.B.I. if the low level is due to hypopituitarism. There is no increase if the low level is due to hypothyroidism.



# The Heart Page

William R. Scarborough, M.D. — Coeditors — Kyle Y. Swisher, M.D.

A SERVICE OF

THE HEART ASSOCIATION OF MARYLAND

## ANGINA PECTORIS TREATED BY DIGITALIS AND DIURETICS

BENJAMIN M. BAKER, JR., M.D.

The hemodynamic consequences of myocardial infarction have been carefully studied by modern techniques. Consequently, the clinician approaches a given patient with myocardial infarction knowing that adequate physiological studies have demonstrated that the circulation may be normal or deficient with the features of either congestive failure or shock. Prior to these definitive circulatory measurements it was only the occasional physician who dared use digitalis or agents to combat shock in myocardial infarction. Now, because of a better understanding of what one is trying to correct in the circulatory failure of coronary artery obstruction, the immediate therapy for this condition is on a sound footing.

Until recently little was known of the circulatory behavior which either accompanies or results from the myocardial ischemia of an attack of angina pectoris. Information on this point stems from a somewhat daring study upon the hemodynamic consequences of an attack of angina pectoris. Patients with angina pectoris who were free of congestive failure in the conventional sense were subjected to right heart catheterization. Most were found to have normal hemodynamics at rest but strikingly abnormal ones during attacks of angina pectoris which were induced by exercise or developed spontaneously. Hemodynamic evidence of left ventricular failure, occasionally to a degree where pulmonary edema is imminent, quite regularly preceded the onset of anginal pain and promptly disappeared when exercise was terminated and pain subsided. Furthermore, when nitroglycerine was given, an amount of exercise, which had previously induced both pain and elevation of pulmonary vascular pressure to congestive failure levels, was easily tolerated without either.

Do these observations clarify anything encountered clinically in patients with angina pectoris such

as do the physiological studies upon patients with myocardial infarction? The answer with some reservation is in the affirmative. Angina decubitus like angina pectoris of effort, usually though not always, occurs in patients whose hearts are of normal size and who are without any of the usual manifestations of congestive failure. And yet some of these patients have been observed to derive great relief from their nocturnal attacks of angina pectoris as a result of the administration of digitalis or diuretics. Just why this should be so is not altogether clear but the catheterization results just described make congestive failure therapy for patients with angina decubitus more plausible than it was when it was purely empirical.

Because angina of effort is so much more common than angina decubitus it is most important to know whether it would be favorably modified by congestive failure therapy. There are but few recorded experiences upon the effects of administering digitalis or diuretics to patients with angina pectoris of effort. At least one indicates that digitalis is of no value but others dealing particularly with control of tissue fluids by diets and the administration of diuretics, indicate a considerable improvement in the exercise tolerance of patients with angina pectoris.

Physicians should realize that the evaluation of any therapeutic measure directed toward the relief of angina pectoris is extraordinarily difficult in view of the prejudiced impressions of patients and the lack of any method which physicians can employ in practice to tell them whether this or that therapy has enhanced coronary blood flow or improved myocardial function.

Until these important considerations are clarified, the physician should cautiously administer digitalis and diuretics to patients with angina decubitus as well as to those with angina pectoris of effort who are resistant to the usual methods of therapy.

9 East Chase Street  
Baltimore 2, Maryland



## BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.  
COMMISSIONER

P. O. Box 1877 Baltimore 3, Md.

Plaza 2-2000: Extension 307

*Learn To Do Your Part In The Prevention Of Disease*

### THE NEW BALTIMORE HEALTH SURVEY

A new and continuous watch over the health of Baltimore's population has recently been launched by the City Health Department. Preliminary steps for the plan, to be known as the Baltimore Health Survey, were taken on September 28 with the inauguration of a pilot study by the Health Department's Research and Planning Section.

During 1960 about 1,200 randomly selected families will be visited by public health nurses and other staff workers. In general the objectives of this continuing survey will be

1. To collect information on the extent of illness in the city's population.
2. To continue the field investigations on the extent to which the population is protected against such preventable diseases as poliomyelitis and diphtheria.
3. To study the movement of the city population as a whole and also of selected portions thereof.
4. To investigate other questions of material importance to the Baltimore City Health Department and other governmental agencies. For example, in connection with the Maryland State Coordinating Commission on Problems of the Aged the Baltimore Health Survey will secure data related to the hous-

ing, medical care and employment of our senior citizens.

The Baltimore Health Survey will be an additional means for providing needed health data and information. By taking its place along with the existing system of compiling death and communicable disease statistics it will strengthen the City Health Department techniques for obtaining medical and public health intelligence.

Many studies of this kind have been made in Baltimore by the public health nurses and others over the past quarter century. Those known as the Family Studies in the Eastern Health District made for the Johns Hopkins School of Hygiene and Public Health were internationally known for their value, and others were made in the City by the U. S. Public Health Service. The new element now added is that the Baltimore Health Survey has been permanently established as a study and analysis project. It will be guided by Dr. Matthew Tayback, Assistant Commissioner of Health for Research and Planning and Mr. Todd M. Frazier, Director of the Bureau of Biostatistics.

*Huntington Williams, M.D.*

*Commissioner of Health*

### ONE CALL DOES IT ALL

One call to the HELP office—MA 3-0393—from the attending physician, a visiting nurse, social agency or hospital can expedite the location of needed medical equipment.

This equipment can be borrowed by individuals from the medical loan closets in this area. These medical loan closets have such equipment as walkers, crutches, wheelchairs, hospital beds, etc.

This is a service we expect to give. We plan to be listing additional equipment as the need increases through your calls.

**THERE IS NO FEE FOR THIS SERVICE**



## MARYLAND TUBERCULOSIS ASSOCIATION

*Christmas Seal Agency for State of Maryland*

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

### THE WORK OF THE CHRISTMAS SEAL

An American tradition for more than 50 years, the Christmas Seal is the source of funds for the work of some 3,000 voluntary tuberculosis associations in this country. With funds raised by the annual Christmas Seal sale, these associations conduct their tuberculosis control programs the year around.

The Christmas Seal originated in Denmark in 1904, when a post office worker named Einar Holboell found himself all but bogged down under a huge lot of Christmas mail. Herr Holboell was an ordinary man with an extraordinary concern for sick and needy children at Christmas time.

As he sorted the mail one day, he thought, "Suppose we could get people to buy a special Christmas stamp while the holiday spirit of giving is strong. There are so many letters and packages—just a penny seal on each one would bring a lot of money. There might even be enough to start a hospital for children." The outcome of this idea was the first Christmas Seal Sale, and enough money was raised to build a children's tuberculosis hospital.

That same year tuberculosis was rife in this country. When the Danish-American writer, Jacob Riis, received a letter from Denmark which bore a Christmas Seal, he wrote an article pleading for someone here to borrow the idea in order to fight tuberculosis in this country. Coincidentally, this was the year which saw the formation of the National Tuberculosis Association.

It was not until tuberculosis went on its killing way for three more years that anyone did plan to fight the disease with Christmas Seals in America. Along the Brandywine River, in Delaware, a group of doctors had built a shack to be used as a tuberculosis hospital. In a short time they ran out of funds; the public was apathetic. One of the doctors, Joseph Wales, explained the plight to his cousin, Miss Emily Bissell, of the Red Cross. Miss Bissell had read the Riis article and decided to attempt the Christmas

Seal plan herself. Although no one before had ever heard of raising money a penny at a time, she did it. In fact, she raised ten times more money than the Brandywine shack needed. A way had been found for all to fight tuberculosis.

The following two years the American Red Cross sponsored the Christmas Seal sale nationally. In 1910 the National Tuberculosis Association was invited to join forces, and by 1920 the Association had grown enough to carry on alone. By now the bright red double-barred cross had become the emblem of the Christmas Seal and of a crusade against tuberculosis. Today's 3,000 tuberculosis associations can count with justifiable pride the number of battles they have fought and won against the disease—all because of a little perforated and gummed stamp!

Exactly what is done with the money people spend on these Christmas Seals? Consider what the Maryland Tuberculosis Association and its 22 local affiliates are doing. Remember that these programs and activities are duplicated by all the other associations.

Here is how the Christmas Seal works against tuberculosis. First, chest x-ray casefinding programs are offered in cooperation with city, county and state health departments. Hundreds of thousands of Marylanders have had chest x-rays made possible through these programs. High incidence areas are the prime targets. In Baltimore City, the Association maintains its own Chest X-ray Screening Center for this free Christmas Seal service.

Secondly, perpetual effort is made to educate the public. The truth about tuberculosis is presented, misconceptions are corrected and apathy destroyed. Not only is this educational program aimed at the general public, funds are also available for hospital training and in the form of grants to individuals to continue their medical education in tuberculosis control.

In addition to maximum use of newspaper, radio and television news outlets, further information is provided for nursing groups, medical doctors and schools.



Medical research is supported by Christmas Seal contributions. Projects currently being investigated in Maryland and across the country will have much bearing on future tuberculosis treatment. The search for a "miracle" preventive or cure is everywhere a major Christmas Seal endeavor.

Another Christmas Seal weapon against tuberculosis is in the form of special services to patients. Provision of clothing and other personal needs is but one of these services. Meetings between a medical social worker and the patient, along with his family, lead to solutions of the myriad of severe emotional and financial problems which are often the immediate result of the diagnosis of tuberculosis. The patient is helped to reach an understanding of what tuberculosis really is and what he must do. He is helped to return to a normal and productive life upon recovery.

These are the four major ways in which the Christmas Seal works. In Maryland, where our tuberculosis rates are so alarmingly high that our case rate is fifth highest in the nation, and our death rate is seventh highest, tuberculosis is indisputably a major public health problem.

With continued support of the public through the annual Christmas Seal sale supplemented by well planned programs and aggressive leadership, the Maryland Tuberculosis Association and its 22 affiliates can continue its work. The Association is prepared to determine precisely what measures are needed to solve the individual tuberculosis problem of any locality in the state. The Association hopes to see the Christmas Seal remain in its established position as the symbol of public interest in eliminating tuberculosis until, hopefully, someday it will be one more disease relegated to history.

#### THE HIDDEN TEAR

"The Hidden Tear," a new 16-mm. motion picture with sound about a successful rehabilitation program for asthmatic children, was premiered August 21 at the annual meeting of the West Virginia State Medical Association in White Sulphur Springs and is now available for showing to medical and lay groups throughout the country.

The film, which runs about 15 minutes, shows the rehabilitation program developed by Merle S. Scherr, M.D., chief of the Allergy Section, Charleston Memorial Hospital, Charleston, W. Va., as it is carried out by Lawrence Frankel, physical education director of the Charleston YMCA. It was filmed in the Charleston Public Schools and the YMCA gymnasium. All of the characters, except one adult, were actually participating in the rehabilitation program.

Although presented in a manner readily understood by laymen, the film is sufficiently detailed to be of interest to a professional audience, particularly general practitioners and allergists concerned with asthma and its relief.

"The Hidden Tear," production of which was made possible by a grant from Warner-Chilcott Laboratories division of Warner-Lambert Pharmaceutical Company, may be obtained for showing under medical auspices to professional or lay groups. Requests for a print of "The Hidden Tear" should be addressed to Mr. George Rohrmann, Film Dept., Warner-Chilcott Laboratories, Morris Plains, N. J.

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## Book Reviews

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**Hypertension: The First Hahnemann Symposium on Hypertensive Disease.** Edited by John H. Moyer, M.D. W. B. Saunders Company, Philadelphia and London, 1959. 790 pages. \$14.00.

In December, 1958 outstanding investigators and clinicians participated in a symposium on hypertension at the Hahnemann Medical College and Hospital. The proceedings of this symposium are published in this book. They should be of particular value to the practicing physician because therapy is emphasized. The initial papers consider the clinical manifestations and etiology of hypertension; the latter part of the book is oriented to therapeutic considerations, medical and surgical.

**Patient Care and Special Procedures in X-ray Technology.** Carol Hocking Vennes, R.N., B.S. and John C. Watson, R.T. The C. V. Mosby Company, St. Louis, 1959. 203 pages. \$5.75.

A modern concept of nursing is based on the belief that patient care should be continuous, smoothly integrating the efforts of all concerned, with due regard for the necessary diagnostic and therapeutic techniques. A thorough understanding and integration of all the steps to be taken in patient examination is particularly applicable in radiography. The authors of this book have compiled a complete presentation of the principles of nursing care related to radiography, and have applied these principles in a specific manner to each of the many techniques used by the well-trained technician.

**Practical Notes on Nursing Procedures.** Second edition. Jessie D. Britten, S.R.N. The Williams & Wilkins Company, Baltimore, 1959. 196 pages. \$4.00.

Written for student nurses and pupil assistant nurses, this book presents a concise outline, enhanced with clear drawings, of basic nursing procedures. It does not err on the side of assuming too much previous knowledge on

the part of the reader. Use of simple tabulation enabled the author to include an immense amount of easy to understand detail and instruction in a small book.

**Fundamentals of Otolaryngology.** Third edition. Lawrence R. Boies, M.D. W. B. Saunders Company, Philadelphia and London, 1959. 510 pages. \$8.00.

The purpose of this volume is to present only fundamental information to the undergraduate medical student or the physician who is not a specialist in otolaryngology. This edition has been brought up to date, and contains the newest developments in otolaryngology.

**Now or Never: The Promise of the Middle Years.** Smiley Blanton, M.D. Prentice-Hall, Inc., New York, 1959. 273 pages. \$4.95.

This book is written for men and women approaching middle age. At this point, according to the author, an individual should be standing triumphantly at the summit of his full development as a human being. Yet, this practicing psychiatrist finds people approaching their middle years unhappy, frustrated, and beset with problems. He has written this book with the idea of giving these people some self-understanding, believing that new insight can change their attitudes and their lives, and give them confidence to meet this age happily and realistically.

**Diseases of Metabolism: Detailed Methods of Diagnosis and Treatment.** Fourth edition. Edited by Garfield G. Duncan, M.D. W. B. Saunders Company, Philadelphia and London, 1959. 1104 pages. \$18.50.

The objective of this edition is to bring into focus progress in methods of investigation with changing concepts that have ensued. Modifying influences which these changes exert in the clinical field of metabolism are incorporated in this edition.

IF YOU KNOW A MAN BY THE BOOKS HE READS, WHAT KIND OF  
A DOCTOR ARE YOU? USE YOUR LIBRARY.

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## NURSING SECTION

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M. RUTH MOUBRAY, R.N., *Executive Secretary,*  
*Maryland State Nurses Association*

*Journal Representative*

### TRAINEESHIP FUNDS

The Professional Nurse Traineeship program, originally established for a three-year period under the Health Amendments Act of 1956, has been extended by congressional action for five years beyond the original termination date of June 30, 1959.

Traineeships will continue to be available to nurses for full time academic study in preparation for supervision, administration, teaching and public health. Beginning this year, a portion of annual traineeships funds will be set aside for nurses enrolled in short-term intensive training courses designed to improve their skills in the supervision and administration of nursing services.

Trainees are selected by the institution providing the training. Application is made directly to the institution. Requirements for all trainees are that they be graduates of state-approved schools of nursing, be citizens of the United States (or have taken steps to become citizens), meet admission requirements of the school in which they plan to enroll, and qualify in terms of academic and personal standards and financial need.

The School of Hygiene and Public Health, The Johns Hopkins University and the University of

Maryland School of Nursing are participating in the Professional Nurse Traineeship program, which is administered by the Public Health Service, United States Department of Health, Education and Welfare.

### ENROLLMENT IN SCHOOLS OF NURSING

Professional nursing schools in the United States admitted 45,297 students in 1958. This marked an upswing in admissions, from 44,004 in 1957, but it was less than a new high of 46,600 which had been estimated in January by the National League for Nursing Committee on Careers.

Maryland professional schools of nursing admitted a total of 810 students in 1958, compared with 813 in 1957. Of these, 635 were to diploma programs and 175 to degree programs. In 1957 there were 634 admissions to diploma programs and 179 to degree programs. Two schools, one offering a diploma program and one a degree program, admitted no students in 1958. Total enrollment dropped from 2,090 in 1957 to 2,066 in 1958. Withdrawals increased from 227 in 1957 to 230 in 1958.

In schools of practical nursing in Maryland, 384 students were admitted in 1958, compared with 275 in 1957.

"Care for any segment of our population—the aged included—calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders and others. It requires flexibility of medical technique—an ingredient which would unquestionably vanish the moment government establishes a health program from a blueprint calling for mass treatment."

Frederick C. Swartz, Chairman of the A.M.A. Committee on Aging



# Woman's Auxiliary Medical and Chirurgical Faculty



MRS. E. RODERICK SHIPLEY *Auxiliary Editor*

NOVEMBER, 1959

## THANKSGIVING MESSAGE

*Make a joyful noise unto the Lord, all ye lands.*

*Serve the Lord with gladness: come before his presence with singing.*

*Know ye that the Lord He is God: it is He that hath made us, and not we ourselves; we are His people, and the sheep of His pasture.*

*Enter into His gates with thanksgiving, and into His courts with praise: be thankful unto Him, and bless His name.*

*For the Lord is good; His mercy is everlasting; and His truth endureth to all generations.*

*Psalm 100*

As we approach the Thanksgiving season, let us be conscious of the many things for which everyone in this country should be thankful, and especially we as doctors' wives.

While many are concerned with outer space, our husbands are working daily to improve the physical and mental health of all people. With God's help, many strides have been made in medicine during the last 50 years. New treatments and medications have restored countless people to useful lives.

Our American way of life begins in the home. We should be thankful for the privilege of making a home, raising a family and being free to raise that family as we believe it should be raised. Our constitutional right assures us of freedom from fear, freedom from want, freedom of worship and freedom of speech. The freedom we have today was won by the sacrifices of many people in the past. We, too, must be willing to make sacrifices for those things in which we believe. At a time when fear and misunderstanding are all about us, we doctors' wives must be willing to give of our selves, talents, time and means to help others understand how fortunate Americans are to have the privilege of freedom in medical practice. Indifference will not preserve this for us; only striving hard every day will keep it for those who follow.

Let us be thankful for the privilege of working beside our husbands on a program that will increase the layman's knowledge of how to live a longer and healthier life.

Gratitude is due to God for all that we have accomplished and will accomplish in the future.

Mrs. D. Delmas Caples  
*President*

## REPORT ON THE 36TH ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

*Atlantic City, June 8-12, 1959*

There were 1413 members registered, with 284 authorized delegates (one for 300 membership). 232 answered roll call for voting. All 48 states were represented, as well as Hawaii with two delegates; there were none from Alaska. An attempt will be made to group this report under the headings of our own standing committees.

A.M.E.F.

To date the auxiliaries have given 137,291 dollars, with 31 states' reports in. The quota for 1959-60 is

175,000 dollars, with a request that each member be responsible for five dollars. In the A.M.E.F. state awards, Nevada won by giving \$4.80 per member. There is no medical school in this state. In the county awards, Mississippi won in the 1-25 membership class by raising 575 dollars.

## SAFETY

An excellent talk was made by Frank Burrows, of the Chicago Traffic Safety Board and an amateur magician, whose tricks held everyone's attention. It was titled, "What are You Going to do With



the 30 Seconds You Save by Going Through a Yellow Light?"

El Paso, with the help of 33 civic and women's clubs, and with the full cooperation of police and other municipal officials, challenged the men of the city to prove who were the safer drivers. Records were kept over a six week period, and the women were proven better drivers by five to one. Florida published a safety booklet for children with rhymes and illustrations.

#### MENTAL HEALTH

Wisconsin contacted each mental hospital in the state and asked each patient who had had no outside contact for two years to make a request in his own handwriting for a most wanted gift. Code names were used and 1400 gifts sent.

A talk on "Alcoholism" by Dr. Marvin Block revealed that one of every 15 persons is an alcoholic, with as many women as men. An alcoholic can never return to social drinking, he said.

#### CIVIL DEFENSE

Colonel Ingalls Simmons, speaker, reported the U.S.S.R. has a required course of ten hours for every adult. We must have an adequate food supply for two week period in our homes. Furnace systems and hot water heaters are sources of uncontaminated water; bottled drinks are another. Blankets make good stretchers. A battery operated radio is a must. Consider the possibility of dysentery outbreaks. Twenty-seven per cent of Hiroshima's pregnant women delivered or miscarried following attack.

#### TODAY'S HEALTH

This magazine will now be sent to all doctors at no cost, but we may still give it as a gift. Membership in the World Medical Association was suggested as a project in its stead. This group, composed of 55 nations, exchanges information and is as old as the United Nations. The Journal of the A.M.A. now goes to 10,000 M.D.'s overseas. 70 countries have made 800 requests for A.M.A. films.

#### DOCTOR'S DAY

Missouri was influential in getting Hallmark to design a Doctor's Day Card.

#### COMMUNITY SERVICE

New York Members staffed a popular health booth at the State Fair. New Hampshire sponsored

two Blood Donor days and a clean-up day, in which they stripped their husbands' offices of excess samples and unwanted instruments, sending them overseas. Michigan made a house to house survey in a designated urban area of 14 blocks to tell of the mobile x-ray unit. By furnishing transportation and baby sitters, there was 100 per cent participation, and many cases of tuberculosis and cancer were detected.

New Mexico sent 16 bus loads of high school children to a military installation for a Space Medicine course. Kentucky doctors' wives and their husbands bought, renovated and furnished Dr. Ephraim McDowell's home to make it a shrine. One of the drug firms restored and stocked the old apothecary shop as this great man had it. Minnesota wives acted as hostesses to the W.H.O. meeting. Ohio had its first doctor sponsored health fair in Columbus, with 100,000 attending.

Hawaii had a Lei Day and invited the presidents of all women's clubs for better relationship. One of the Hawaiian Islands, with only 26 members, gave 1400 volunteer hours. Texas estimated its volunteer hours in terms of bricklayers' wages and found an astronomical figure. With the reports of only 31 states in, nationally we have given 12,500,000 hours in volunteer work.

#### FUTURE NURSES AND PARAMEDICAL CAREERS

Illinois has 11,000 dollars on loan and in scholarships in these fields. Iowa has a state convention of Future Nurses Clubs with every high school in the state participating. Paramedical fund was derived from a 50 cent assessment from each member, and they held a workshop for these students. Nebraska entertains all high school students interested in these careers and has loan fund. West Virginia increased its loan fund by 2,000 dollars by not sending Christmas cards to doctors and has given 28 scholarships to nurses.

#### LEGISLATION

Only 177,000 doctors against seventeen and a half million votes by labor. We must defeat the Forand Bill. Talk to Congressmen, their wives, civic clubs and everyone else, but be sure your state is offering an adequate substitute. There are 21 different plans available through Blue Cross and Blue Shield. Great Britain, with its socialized

medicine, last year spent 2,850,000 dollars for bottles alone to hold the free medicine and anticipate the cost to be five times as great this year. Then spent only 75,000 dollars for mental health.

#### GERIATRICS

This is our major project. There are now 15,000,000 people over 65 years in the United States. Work for improvement in nursing homes. Develop a homemakers service, whereby the elderly can stay in their own homes and have trained personnel come in to help. Integrate them into the life of the community if they are physically able. Minnesota teaches crafts to the aged and has an annual hobby show. Our husbands are adding to the lives of these people; let us see that they live them in dignity. Maintain them ourselves and follow our forefathers' concept of independence that the government is dependent on us, not we on it.

#### THE DOCTOR'S WIFE

This magazine should not be an auxiliary project.

#### AMENDMENTS TO BYLAWS VOTED AND PASSED

##### Article VI, Section 2. b)

"The President of each constituent auxiliary or, in the absence of the President, the President-elect or, in the absence of both of these officers an official representative appointed by the constituent auxiliary, and . . . (Each State will decide how to appoint the official delegate, but more than one person should make the decision.)"

##### Article V, Section 3. Deleted

(Auxiliaries no longer required to collect delinquent National dues.)

Maryland was one of four states asked to give special reports. Mrs. Caples' work on the organization of the Future Nursing Clubs was enthusiastically received, and many asked for copies. Mrs. Albert E. Goldstein was elected to the Board of Directors for a two year term. Mrs. Caples and Mrs. Stone were official timekeepers.

#### New National officers are:

President: Mrs. Frank Gastineau, Indianapolis, Indiana

President-elect: Mrs. William Mackersie, Michigan

First Vice President: Mrs. Charles Goodhand, West Virginia

Eastern Region Vice President: Mrs. Paul E. Raushenbach, New Jersey

Northern Central Region V.P.: Mrs. Stephen C. Bacheller, North Dakota

Southern Region Vice President: Mrs. William G. Thuss, Alabama

Western Region Vice President: Mrs. L. D. Jacobson, Oregon

Secretary: Mrs. W. W. Hubbard, Tennessee

Treasurer: Mrs. Harlan English, Illinois

Directors: Mrs. Roger H. Cheney, Massachusetts;

Mrs. Albert E. Goldstein, Maryland; Mrs.

Stanley R. Truman, California.

Mrs. William S. Stone

*State Chairman of Delegates*

### INTRODUCING OUR COUNTY PRESIDENTS



Mrs. Robert P. Conrad

Mrs. Robert P. Conrad, president of the Washington County Auxiliary, is the wife of a Hagerstown physician. She is a former school teacher who looks upon teaching as a pleasant part of her life. Civics and ancient history were the subjects she taught at Woodland Way School, her first and only post. Lebanon Valley College, Annville, Pennsylvania was where she received her training in the field of educa-

tion. While at college, as an assistant to the English professor, she tutored freshman students. To this day she tutors students who ask her help. Mrs. Conrad was active in college as a member of W.W.C.A., Life Work Recruits, Readers Club, and the college year-book staff.

A native of Bergenfield, New Jersey, she came to Hagerstown in 1935 to teach school. She later married Dr. Robert P. Conrad and retired to a busy life as a doctor's wife, performing numerous community services.

Mrs. Conrad organized the Washington County chapter of the Women's Division of the National Foundation for Infantile Paralysis, and headed the 1949 March of Dimes when the organization was complete.

The Hagerstown Girl's Club claims her services as publicity director. Mrs. Conrad was active in the formation of this club, having attended the organizational meeting as a representative of the Washington County Council of Church Women (interdenominational). She terms the Girl's Club one of the most worthwhile activities in the community.

Mrs. Conrad is associated with the County Council of Church Women and has talked on the subject of racial problems. She is a member of St. John's Episcopal Church. In this realm she conducts the School of Missions and is a member of the Altar Guild, Service League, Turnover Shop volunteer, and substitute Sunday School teacher.

She is chairman of the Washington County Polio Chapter, a member of the Woman's Club, serving on library, civic and dramatic groups, a member of the Fountain Head Country Club, Nine Hole Golf Group and chairman of various committees for both the local and state levels of our Medical Auxiliary.

Robert Jr., their son, was recently married and is studying medicine. The Conrads are proud that he has chosen this field without any parental prompting.

Mrs. Conrad collects hobnail glass and is fond of antiques. She spends her free time with her family and feels the work which she does outside her home provides a practical and diverting occupation, for which there is no other reward than the satisfaction of a job well done.

### BALTIMORE CITY AUXILIARY NOTES

The Baltimore City Auxiliary is publishing a unique news letter, titled "Private Lives of Doctors' Wives." Mrs. E. Ellsworth Cook is editor.

On the agenda for the City auxiliary meetings this fall are some interesting topics: In October their program "To Hypnotize or not to Hypnotize," presented by Dr. Harold Rosen, a nationally known psychiatrist and author and the husband of one of their members.

A fall fashion show is to accompany a luncheon and cards at the Emerson Hotel. A report on this venture (we are sure of its success) will be forthcoming later.

This month, November, the topic will be "Your Family's Life is at Stake," with Dr. I. Ridgeway Trimble as the speaker. Dr. Trimble is the Faculty chairman of the Committee on National Emergency Medical Service. There are plans, at this writing, to have a portable model of an approved bomb shelter, completely stocked, on hand for this meeting. The portable model will be used many times, it is hoped, by other groups to stress the importance of civilian defense. It will provide another opportunity for community service and good public relations. The model is being made by students at the Maryland Institute of Art. It is to be constructed of canvas and wood, in full size. It is to be painted to simulate the actual materials that should be used in a home shelter. Mrs. Raymond L. Markley, chairman of Civilian Defense, has made the arrangements for this model.

As the two patients were leaving the doctor's office one asked the other, "Did Ole Doc find out what you had?" "Heck, no," was the reply. "He charged me three dollars and I had three and a half with me!"

# CALENDAR OF EVENTS

## TUESDAY, NOVEMBER 10

### PEDIATRIC SECTION, B.C.M.S.

8:30 P.M. 1211 Cathedral Street  
"Current Status of Common Viral Diseases in Pediatrics"  
(Illustrated) Fred R. McCrumb, M.D.

### OTOLARYNGOLOGICAL SECTION, B.C.M.S.

6:15 P.M. University Club

## THURSDAY, NOVEMBER 12

### NEUROPSYCHIATRIC SECTION, B.C.M.S.

in Cooperation With The Maryland Association of Private  
Practicing Psychiatrists

8:30 P.M. 1211 Cathedral Street

#### "TREATMENT OF THE CRIMINAL OFFENDER."

DR. MANFRED S. GUTTMACHER, *Moderator*, Chief  
Medical Advisor, Supreme Bench of Baltimore.

#### *Panelists:*

DR. HAROLD M. BOSLOW, Director, The Patuxent  
Institute.

DR. JEROME D. FRANK, Professor of Psychiatry, The  
Johns Hopkins University School of Medicine.

DR. PETER LEJINS, Professor of Sociology, The Uni-  
versity of Maryland.

HONORABLE JOSEPH SHERBOW, Former Judge,  
Supreme Bench of Baltimore.

## SATURDAY, NOVEMBER 14

### TELEVISION PROGRAM, B.C.M.S.

5:00 P.M. WMAR-TV, Channel 2  
"Electricity in Medicine"—Dr. William B. Kouwenhoven

## MONDAY, NOVEMBER 16

### PATHOLOGY SECTION, B.C.M.S.

8:00 P.M. Montebello State Hospital

## WEDNESDAY, NOVEMBER 18

### WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

12:00 Noon 1211 Cathedral Street  
Luncheon

1:30 P.M.

Program: "Your Family's Life is at Stake," I. Ridgeway  
Trimble, M.D.

## THURSDAY, NOVEMBER 19

### OPHTHALMOLOGICAL SECTION, B.C.M.S.

6:00 P.M. Dinner Meeting Marty's Park Plaza  
"Further Studies in Glaucoma," John McLean, M.D.



**MONDAY, NOVEMBER 23****DERMATOLOGY SECTION, B.C.M.S.**

8:00 P.M. 1211 Cathedral Street

**ORTHOPAEDIC SECTION, B.C.M.S.**

8:00 P.M. The Children's Hospital

**TUESDAY, NOVEMBER 24****ANESTHESIA STUDY COMMITTEE**

8:00 P.M. 1211 Cathedral Street

**SATURDAY, NOVEMBER 28****TELEVISION PROGRAM, B.C.M.S.**

5:00 P.M. WMAR-TV, Channel 2

"Cataracts and Glaucoma"—Dr. Stewart M. Wolff

**FRIDAY, DECEMBER 4****BALTIMORE CITY MEDICAL SOCIETY**

Annual Meeting

8:30 P.M. 1211 Cathedral Street

**TUESDAY, DECEMBER 8****MARYLAND RADIOLOGIC SOCIETY**

Johns Hopkins Medical Resident Hall

Broadway and McElderry Streets

5:30 P.M. Film reading session

6:30 P.M. Cocktails

7:00 P.M. Dinner

8:00 P.M. "Pulmonary Fungus Disease," D. A. Wolfel,  
M.D., Department of Radiology, University Hospital**WEDNESDAY, DECEMBER 9****CANCER SECTION, B.C.M.S.**

8:00 P.M. University Hospital